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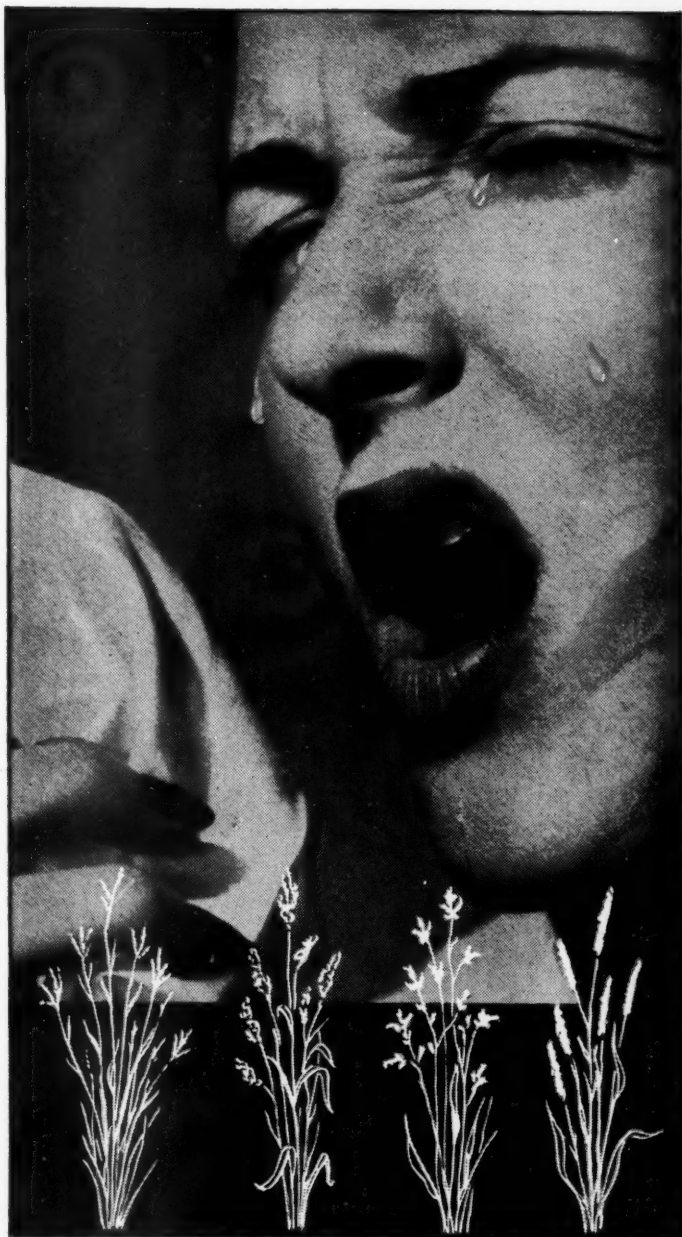
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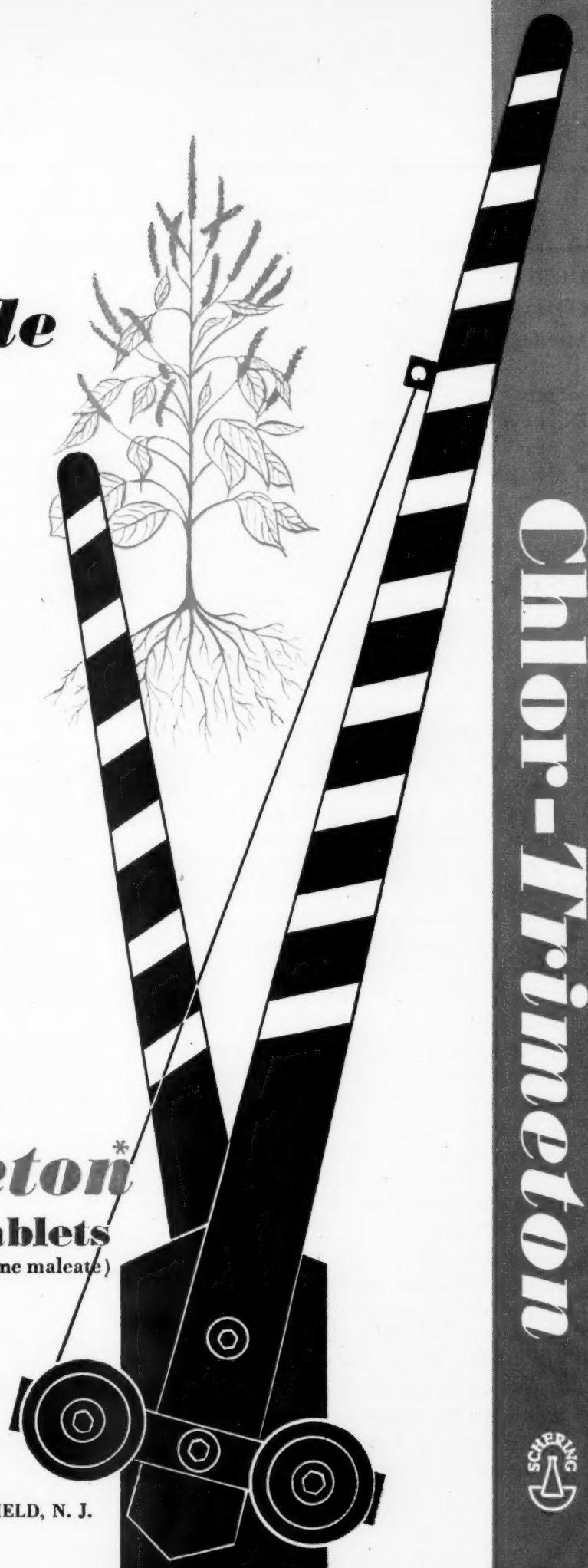
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MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
GRAND RAPIDS—September 26-27-28, 1951

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL Meeting of March 15, 1951

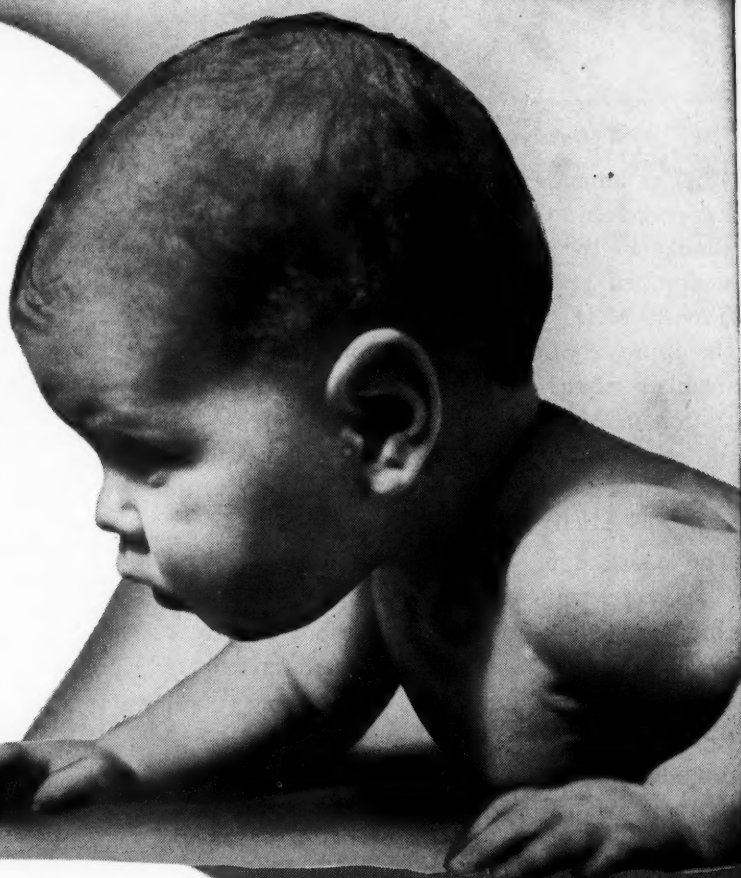
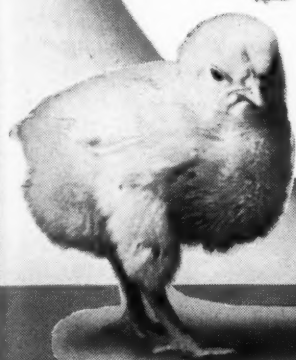
Forty-seven items were considered by the Executive Committee of The Council at its March 15 meeting. Chief in importance were:

- Monthly financial reports were presented and approved. Bills payable were inspected and authorized to be paid.
- Purchase of property at 606 Townsend Ave., Lansing, for MSMS Executive Offices: the Executive Committee of the Council authorized cashing of necessary bonds to consummate this transaction, after all legal documents have been approved by the MSMS Legal Counsel.
- Possibility of reactivation of EMIC Program. T. A. Hendricks of the AMA Council on Medical Service invited attention to this matter; the program is desired by the American Legion and also by the UAW-CIO President who favors its activation through Blue Cross-Blue Shield.
- Legal Counsel J. Joseph Herbert reported on (a) Grand View Hospital in Ironwood and attempts of chiropractor to practice therein; (b) Bill in Michigan Legislature to transfer maternity inspections from State Welfare Department to State Health Department; (c) Proposed amendment to Social Welfare Act to permit Welfare Department to enter into contracts for medical services to be rendered to recipients, with payments direct to contractors.
- Committee reports. The following Committee reports were given consideration: (a) Mental Hygiene Committee, meeting of January 25; (b) Liaison Committee with UAW-CIO, meeting of February 13; (c) Special Committee on proposed Tuberculosis Bill, meeting of March 14; (d) Committee on Improvement of Nursing Service, meeting of February 19; (e) Permanent Conference Committee, meeting of February 21; (f) Meeting of Ubiquitous Hosts for 1951 Michigan Postgraduate Clinical Institute, meeting of March 2; (g) Legislative Committee, meeting of March 8; (h) Report on AMA Rural Health Conference held in Memphis, Feb. 23-24—by John R. Rodger, M.D., Bellaire; (i) Report on Associated State Postgraduate Committee meeting, held in Chicago on February 4 by John M. Sheldon, M.D., Ann Arbor.
- A report on the 1950 accomplishments of the Michigan Rheumatic Fever Control Program was presented by Co-ordinator Leon DeVel, M.D., Grand Rapids.
- Names of A. S. Brunk, M.D., Detroit, and D. R. Smith, M.D., Iron Mountain, and C. E. Umphrey, M.D., Detroit, were submitted to Blue Cross as nominees for two places on the MHS Board of Trustees.
- Report was presented that Michigan Hospital Service has approved the addition of a limited maternity benefit to the Community Enrollment Contract, to be made available in the near future, and a similar benefit is also being made available shortly in Blue Cross Direct Payment Contracts.
- Special recognition to Mr. C. E. Wilson and Drs. Max R. Burnell and C. D. Selby of Detroit for tangible encouragement to industrial medicine, was authorized, to be made at a meeting in Detroit in the near future.
- A letter to all MSMS members, to be signed by President C. E. Umphrey, M.D., re support for Wayne University College of Medicine Science Building project now before the Michigan Legislature, was approved and authorized to be sent.
- Letter urging re-appointment of A. E. Heustis, M.D., as State Health Commissioner, was approved and authorized to be sent Governor G. Mennen Williams.
- A resolution was authorized to be drafted, for presentation to the AMA House of Delegates in June, 1951, incorporating the suggestions of Editor Wilfrid Haughey, M.D., re "Short Lived Incomes of Doctors," seeking to amend existing pension trust provisions under federal tax laws.
- Report of Special Committee to Study Medical Practice Act, meeting of March 15, was presented. This included twenty recommended amendments to Act 237 of the Public Acts of

(Continued on Page 456)

LESS
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OF

Colic



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4 to 6 drops in milk. Bottles of 5, 10 and 50 cc.

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✓ TASTELESS
✓ NONALLERGENIC

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Now also milk diffusible **DRISDOL with VITAMIN A**

(Continued from Page 454)

1899 as amended. The report as a whole was approved by the Executive Committee, with thanks to the Special Committee for its work designated as "a mile stone." Chairman F. L. Troost, M.D., discussed the need for securing the approval of this proposal from the individual members of the Michigan State Board of Registration in Medicine; the final bill is to be submitted to the MSMS Executive Committee of The Council, after drafting, prior to introduction into the Michigan Legislature.

- The question of Joseph F. Beer, M.D., of St. Clair, concerning the new city hospital at Marine City, and the right of various healers to practice therein, was thoroughly discussed and referred to the Secretary.
- Report on Invitational Membership Campaign's progress was presented by the Public Relations Counsel, who also reported on the MSMS motion picture programs and the television program "It's Your Life."
- Reports of the so-called "Little Hoover Commission" of Michigan, re medical phases of government, were studied.

COURSES IN MEDICAL ECONOMICS

University of Michigan Medical School

- April 28—11:00 a.m., "*Rural Medical Practice*"
JOHN R. RODGER, M.D., Bellaire
Chairman, Rural Health Committee, MSMS;
Member, Advisory Committee to State Hospital
Survey and Construction Agency.
- May 5—11:00 a.m., "*Medical Insurance Plans*"
WILFRID HAUGHEY, M.D., Battle Creek
Editor, JOURNAL MSMS; Past President, MS-
MS; Board member, Michigan Medical Service
and Michigan Hospital Service.
- May 12—11:00 a.m., "*Medical Public Relations*"
R. WALLACE TEED, M.D., Ann Arbor
Member, Public Relations Committee, Legisla-
tive Committee, Medical Mediations, and Com-
mittee on Radio, MSMS.
- May 19—11:00 a.m., "*Opportunities in Medical Prac-
tice*"
E. F. SLADEK, M.D., Traverse City
Past President, MSMS; Past President, National
Conference on Medical Service; Past President,
Associated State Postgraduate Committees.

Wayne University College of Medicine

- May 18—11:00 a.m., "*Opportunities in Medical
Practice*"
E. F. SLADEK, M.D.
- May 25—11:00 a.m., "*Rural Medical Practice*"
JOHN R. RODGER, M.D.
- June 1—11:00 a.m., "*Medical Public Relations*"
L. FERNALD FOSTER, M.D., Bay City
- June 8—11:00 a.m., "*Medical Insurance Plans*"
WILFRID HAUGHEY, M.D.

CHILD PSYCHIATRY

A postgraduate school in Child Psychiatry is planned for June 25 through June 29, 1951. This will be intended to answer the needs of the general practitioner and pediatrician, rather than those of the specialist in child psychiatry. It will be an intensive course with four instructors who are prominent men in the field, including Ralph Rabinovitch, M.D., Director, Children's Division, Neuropsychiatric Institute, University of Michigan; Samuel W. Hartwell, M.D., Assistant Director, Michigan Department of Mental Health; Paul H. Jordan, M.D., Director, Flint Child Guidance Clinic.

The fee for the five-day course is \$35.00, payable upon registration. The course is being sponsored by the Kalamazoo Child Guidance Clinic and the State Department of Mental Health, and will be held at Kalamazoo College. Total enrollment is limited to forty physicians. Twenty registrations are open at the present time. Quarters will be provided for a reasonable rate at Kalamazoo College.

Address communications to Ray O. Creager, M.D., Kalamazoo Child Guidance Clinic, 214 Pratt Building, Kalamazoo, Michigan.

PATERNALISM

As we observe the growing paternalism of our government, we wonder what the finale will be. We are prompted to quote a clipping sent us by Lew Buchler when he was in Florida:

"Father, must I go to work?"
"No, my lucky son.
We're living now on Easy Street
On dough from Washington.

We've left it up to Uncle Sam,
So don't get exercised
Nobody has to give a damn,
We've all been subsidized."

"But if Uncle Sam treats all so well,
And feeds us milk and honey.
Please Daddy, tell me what the—
He's going to use for money?"

"Don't worry, Bub, there's not a hitch
In this here noble plan.
He simply soaks the filthy rich,
And helps the common man."

"But, father, won't there come a time
When they run out of cash,
And we have left them not a dime,
Won't things all go to smash?"

"My faith in you is shrinking, son,
You nosey little brat,
You do too darn much thinking, son,
To be a Democrat."

—Kiwanis Club Letter, Battle Creek,
March 22, 1951.

LIVER INJECTION (crude) U.S.P.

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Pyridoxine Hydrochloride.....	1 mg.
Niacinamide	25 mg.
Iron Ascorbate.....	4 mg.
Magnesium Chloride.....	1 mg.
Calcium Chloride.....	1 mg.
Sodium Chloride.....	3.5 mg.
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Second Annual Heart Day Offers New Hope for Hearts

"The Michigan Heart Association will continue its ceaseless efforts in the constant search for the solution to the perplexing problems of diseases of the heart and circulatory system," was the reassuring note sounded by Douglas Donald, M.D., Detroit, who was installed as President of the Michigan Heart Association at its Second Annual Meeting on Saturday, March 17, 1951.

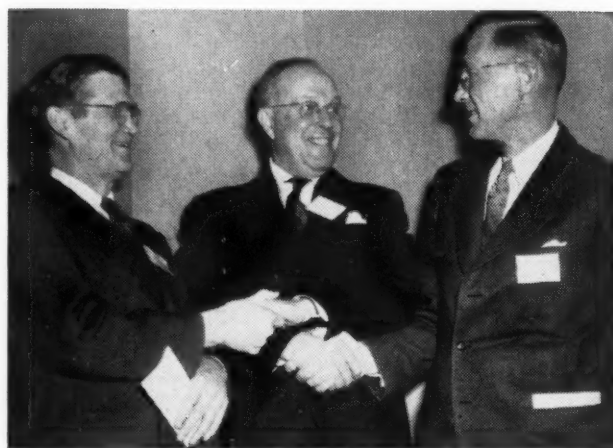
"Heart Day," which was held again this year in conjunction with the Michigan Postgraduate Clinical Institute, featured the presentation of scientific papers on current advancements in the field of heart research.

Paul S. Barker, M.D., retiring President of the Michigan Heart Association, delivered the address of welcome and urged continued support of the Heart Association "which will make possible for the future greater accomplishments in medical science and greater service to the people." As his last official act as President of the Michigan Heart Association, Dr. Barker presented Warren B. Cooksey, M.D., first President of the Association, with a Past President's Key in recognition of his valuable service to the Michigan Heart Association.

F. Janney Smith, M.D., President-Elect of the Michigan Heart Association and Physician-in-charge, Cardio-Respiratory Division, Henry Ford Hospital, reported to the Heart Day audience on a controlled study of the effect of anticoagulants on patients suffering from coronary occlusion. This study involved the use of Dicumarol, alternating with a newer anticoagulant which may be given orally, Tromexan; and a comparative study between the two parenteral anticoagulants, Heparin and Peritol.

"The use of anticoagulant therapy in coronary occlusion and myocardial infarction was found to have a distinctly favorable effect in decreasing the frequency of intravascular clotting and in lowering the mortality rate," Dr. Smith said. "Therefore, it is our belief that anticoagulants should be administered to every patient suffering from acute coronary thrombosis unless a definite contraindication exists."

"Emphasis is placed on the need for the careful



Warren B. Cooksey, M.D. (left) and Paul S. Barker, M.D. (right) congratulate Douglas Donald, M.D., (center) as he takes office as President of the Michigan Heart Association at the Second Annual Heart Day, Saturday, March 17, 1951.

control and handling of anticoagulant therapy by a competent and conscientious internist, or by a team of physicians skilled in this type of work, because if the matter is not carefully handled, the results will not be therapeutically satisfactory, and there will be danger of hemorrhage."

Harry E. Ungerleider, M.D., Medical Director of Research, Equitable Life Assurance Society, informed the Doctors of Medicine of the latest developments concerning the relationship between certain fatty substances in the blood stream of man and arteriosclerotic processes which have been revealed by studies in the ultracentrifuge. Drastic curtailment of fat in the diet is the sole recommendation for the prevention of arteriosclerosis which appears to have some solid foundation, Dr. Ungerleider said.

Albert Dorfman, M.D., Director of Rheumatic Fever Research for LaRabida Sanitarium and the University of Chicago, reported on the work being done with ACTH and cortisone in treating rheumatic fever patients. Dr. Dorfman pointed out that from studies performed to date, the following conclusions seem warranted:

1. ACTH and cortisone are potent agents for the repression of the manifestations of rheumatic fever.

(Continued on Page 460)

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\$ 300	Monthly Benefits thereafter for Life.
Pays \$ 600	Additional Monthly Benefits First 3 Months for Hospital Disability.
Pays \$ 7,500	Accidental Death Benefits, \$12,500 Double Indemnity.
Pays \$10,000	Loss of Hands, Feet or Eyes, \$15,000 Double Indemnity (or)
\$ 5,000	Cash, & \$400 monthly first 2 years, \$300 monthly thereafter. Adjusted benefits for disabilities occurring after age 60.

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No Terminating Age,—Standard Provision 20	Non-Assessable,—No Contingent Liability
No Increase in Premium,—Once Policy is Issued	Non-Aggregate,—Previous Claims Paid do not limit Company's Liability
Grace Period 15 Days	

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- ★ Pays Benefits for both Sickness and Accident.
- ★ Pays Lifetime Benefits for Time or Specific Losses.
- ★ Pays Regular Benefits for Commercial Air Travel.
- ★ Pays Benefits for Non-Disabling Injuries.
- ★ Pays Benefits for Non-Confining Sickness.
- ★ Pays Benefits for Septic Infections.
- ★ Pays Whether or not Disability is Immediate.
- ★ Waives Premiums for Total Permanent Disability.
- ★ Renewal is guaranteed to individual active members, except for non-payment of premium, so long as the plan continues in effect for the members of your designated organization.

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SECOND ANNUAL HEART DAY

(Continued from Page 458)

2. There is evidence that these agents repress the inflammatory lesions in the heart.

3. As yet there is insufficient evidence to decide whether these agents alter the natural course of the

troit. John G. Bielawski, M.D., Detroit, was appointed Executive Secretary of the Association.

C. E. Wilson was re-elected Chairman of the Board of Trustees for the third consecutive year, and the following members were elected to the



Michigan Heart Association exhibit at Michigan Postgraduate Clinical Institute and Second Annual Heart Day, March 14-17, 1951.

disease and prevent the structural deformities which are the frequent consequence of acute rheumatic fever.

A very attractive and effective exhibit, including a complete life-size "heart" kitchen, was displayed by the Michigan Heart Association at the Michigan Postgraduate Clinical Institute and also at the Annual Heart Day Meeting. All equipment and furniture for the kitchen was furnished by the J. L. Hudson Company, Detroit.

The annual meeting of the Board of Trustees and the membership of the Michigan Heart Association followed the scientific sessions, at which time Dr. Donald took office as President, and the following officers were elected for 1951: President-Elect, F. Janney Smith, M.D., Detroit; Vice Presidents, Frank Van Schoick, M.D., Jackson; Mrs. Hugh Wilson, Ann Arbor; Carleton Dean, M.D., Lansing; Secretary, L. Fernald Foster, M.D., Bay City; Treasurer, Charles T. Fisher, Jr., De-

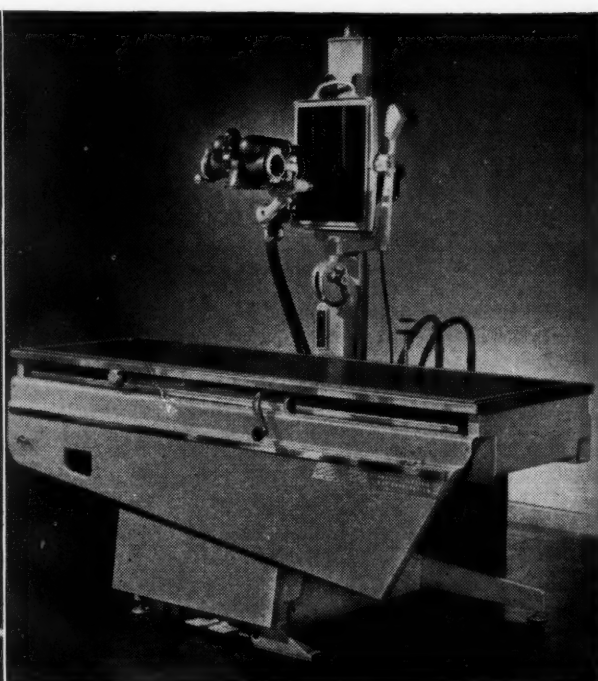
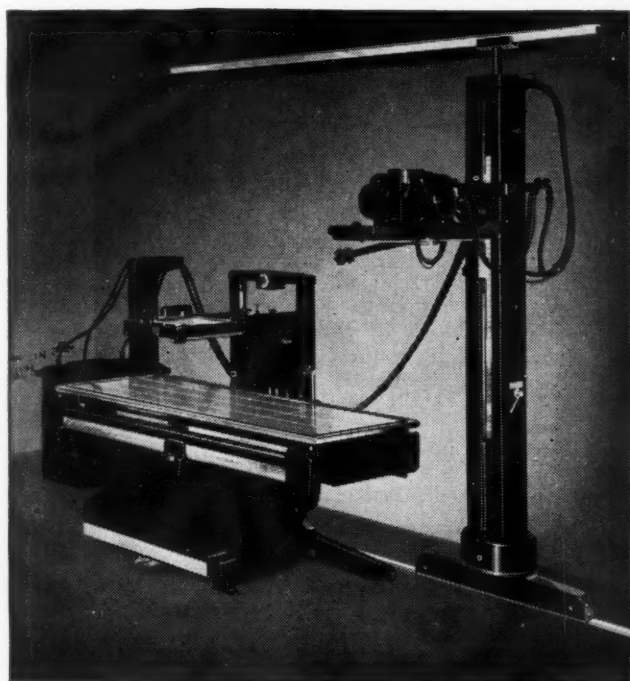
Board with terms to expire in 1954; C. F. Kettering, Detroit; Endicott R. Lovell, Calumet; Mrs. Wm. MacGregor, Detroit; C. J. Reece, Muskegon; Emmet Richards, Alpena; Carleton Dean, M.D., Lansing; Leon DeVel, M.D., Grand Rapids; F. D. Dodrill, M.D., Detroit; Douglas Donald, M.D., Detroit; L. Fernald Foster, M.D., Bay City; Frank X. Martell, Detroit; Edward Cote, Detroit; Mrs. Fred Miner, Flint; J. William Hagerty, Detroit.

The following members were also elected at the Annual Heart Association as delegates from the Michigan Heart Association to the American Heart Association in 1951; F. D. Dodrill, M.D., Detroit; Douglas Donald, M.D., Detroit; F. Janney Smith, M.D., Detroit; Paul Barker, M.D., Ann Arbor; John G. Bielawski, M.D., Detroit; Warren B. Cooksey, M.D., Detroit; Cecil Corley, M.D., Jackson; Carleton Dean, M.D., Lansing; Leon DeVel,

(Continued on Page 462)

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SECOND ANNUAL HEART DAY

(Continued from Page 460)

M.D., Grand Rapids; and Mrs. Hugh E. Wilson, Ann Arbor.

151 M.D.s Present at Heart Conference

Among the 151 Doctors of Medicine who registered at the Second Annual Michigan Heart Day, three foreign countries (Australia, Japan and Ontario) and from five states (Michigan, Ohio, Illinois, Indiana and New York) were represented:

H. B. Appleman, M.D., Detroit; E. C. Armstrong, M.D., London, Ontario, Canada; R. R. Barber, M.D., Plymouth; Paul S. Barker, M.D., Ann Arbor; R. C. Barlow, M.D., Ann Arbor; J. M. Bauer, M.D., Ann Arbor; T. I. Bauer, M.D., Lansing; J. C. Benson, Jr., M.D., Flint; J. G. Bielwaski, M.D., Detroit; T. H. Bottomley, M.D., Port Huron; R. E. Bowsher, M.D., Midland; W. J. Briggs, M.D., Detroit; G. T. Brown, M.D., Detroit; B. M. Bullington, M.D., Saginaw; E. T. Calhoun, M.D., Pontiac; N. T. Caputo, M.D., Detroit; H. W. Carlson, M.D., Detroit; E. K. Carmichael, M.D., Detroit; William Cayce, M.D., Grand Rapids; M. S. Chambers, M.D., Flint; S. E. Chapin, M.D., Dearborn; C. N. Clarke, M.D., Detroit; E. E. Congdon, M.D., Flint; H. C. Conn, M.D., Detroit; E. R. Conrad, M.D., Detroit; W. B. Cooksey, M.D., Detroit; W. F. Cooper, M.D., Melbourne, Australia; Campbell Cutler, M.D., Flint; R. H. Darpin, M.D., Detroit; Carleton Dean, M.D., Lansing; R. H. Denham, M.D., Detroit; H. E. DePree, M.D., Kalamazoo; Leon DeVel, M.D., Grand Rapids; F. D. Dodrill, M.D., Detroit; Douglas Donald, M.D., Detroit; Albert Dorfman, M.D., Chicago, Illinois; E. H. Drake, M.D., Detroit; E. J. Dudzinski, M.D., New Baltimore; E. W. Durham, M.D., Dearborn; I. D. Fagin, M.D., Detroit; A. F. Fath, M.D., Kalamazoo; R. L. Fellers, M.D., Detroit; O. O. Fisher, M.D., Detroit; K. G. Foster, M.D., Detroit; L. Fernald Foster, M.D., Bay City; M. R. French, M.D., Coldwater; J. H. Fyvie, M.D., Manistique; D. P. Gage, M.D., Saginaw; R. A. Gerisch, M.D., Detroit; H. I. Ginsberg, M.D., Detroit; Fred Girton, M.D., Detroit; William Goldberg, M.D., London, Ontario, Canada; B. J. Goldman, M.D., Mt. Clemens; C. J. Golinvaux, M.D., Monroe; B. E. Goodrich, M.D., Detroit; R. P. Goring, M.D., Detroit; R. P. Gripe, M.D., Detroit; R. H. Hamburg, M.D., Detroit; A. C. Hamburger, M.D., Detroit; Kuno Hammerberg, M.D., Clare; E. A. Hasty, M.D., West Branch; L. Heavenner, M.D., Grosse Pointe; M. S. Hecht, M.D., Detroit; R. F. Helzerman, M.D., Tecumseh; J. W. Hill, M.D., Grand Rapids; L. J. Hirschman, M.D., Traverse City; S. W. Hoobler, M.D., Ann Arbor; S. J. Hyman, M.D., Inkster; F. J. Jarsen, M.D., Detroit; E. B. Jewell, M.D., Logansport, Indiana; T. G. Kabza, M.D., Ann Arbor; H. J. Kerr, M.D., Muskegon; R. J. Kokowicz, M.D., Detroit; A. H. Lange, M.D., Detroit; S. P. L'Esperance, M.D., Detroit; Adolf W. Lowe, M.D., Detroit; E. D. Maire, M.D., Grosse Pointe; M. D. Masullo, M.D., Youngstown, Ohio; D. G. May, M.D., Kalamazoo; M. S. Maynard, M.D., Grand Rapids; R. E. McBroom, M.D., Detroit; H. J. McLane, M.D., Detroit; T. P. McWilliams, Jr., M.D., Ann Arbor; C. P. Mehas, M.D., Pontiac; Herbert Meyer, M.D., Detroit; Walter Mikulasehek, M.D., Detroit; C. P. Mott, M.D., Detroit; A. P. Murphy, M.D., Saginaw; J. M. Murphy, M.D., Detroit; S. G. Murphy, M.D., Detroit; P. H. Muske, M.D., Detroit; John W. Nagle, M.D., Wyandotte; J. W. Nunn, M.D., Highland Park; D. C. Overy, M.D., Ann Arbor; T. S. Painter, Jr., M.D., Ann Arbor; J. R. Pedden, M.D., Grand Rapids; C. J. Poppen, M.D., Lansing; L. I. Powers, M.D., Muskegon; F. W. Prather, M.D., Milford; A. E. Price, M.D., Detroit; A. H. Price, M.D., Detroit; L. Paul Ralph, M.D., Grand Rapids; J. A. Ramsey, M.D., Alpena; W. H. Reeder, M.D.,

Detroit; R. M. Rees, M.D., Ann Arbor; R. E. Reichert, M.D., Ann Arbor; H. H. Riecker, M.D., Ann Arbor; J. V. Roberts, M.D., Hamilton, Ontario, Canada; L. H. Roberts, M.D., London, Ontario, Canada; H. C. Robinson, M.D., Grand Rapids; J. S. Rozan, M.D., Lansing; M. J. Rueger, M.D., Detroit; H. J. St. Amour, M.D., Detroit; C. D. Selby, M.D., Detroit; E. M. Shafarman, M.D., Detroit; H. C. Shafer, M.D., Bay City; Milton Shaw, M.D., Lansing; R. E. Shipley, M.D., Detroit; Max Silverman, M.D., Dearborn; F. J. Smith, M.D., Detroit; H. V. Sparks, M.D., Flint; S. A. Stealy, M.D., Grayling; M. J. Steinhardt, M.D., Detroit; A. M. Stern, M.D., Ann Arbor; R. M. Stow, M.D., Ann Arbor; G. C. Stucky, M.D., Charlotte; D. I. Sugar, M.D., Detroit; G. D. Sutton, M.D., Flint; F. C. Swartz, M.D., Lansing; R. V. Taylor, M.D., Jackson; Myer Teitelbaum, M.D., Detroit; T. G. Todoroff, M.D., Detroit; W. E. Truax, M.D., Pontiac; R. V. Tubbs, M.D., Blissfield; H. E. Ungerleider, M.D., New York, New York; Kazuko Uno, M.D., Detroit and Japan; E. G. Upjohn, M.D., Kalamazoo; Frank Van Schoick, M.D., Jackson; J. R. Venema, M.D., Grand Rapids; F. Walter, M.D., Detroit; David Waxman, M.D., Detroit; R. F. Weyher, M.D., Detroit; W. G. White, M.D., Muskegon; S. C. Wiersma, M.D., Muskegon; J. M. Wilkinson, M.D., Detroit.

H.R. 3511—FEDERAL AID TO MEDICAL EDUCATION

To provide for education in the field of medicine through establishment of two Federal medical schools, and for other purposes. Referred to the Committee on Education and Labor.

Comment: Bill creates a corporation within the Federal Security Agency with the name "Medical College of the United States." A Medical College Commission of seven members would be appointed by the Federal Security Administrator on recommendation of Surgeon General of the Public Health Service—members to be leading authorities in medical education or public health and no more than four affiliated with the same political party. The Commission would select sites for two medical schools to accommodate 400 students each, with a teaching hospital of approximately 700 beds in connection with each. Fifty thousand dollars is authorized for a site survey, \$2,000,000 for acquisition of land, and \$20,000,000 for construction of schools, hospitals and dormitories. A permanent appropriation of \$3,000,000 annually would be authorized for costs of administration. Management of the two schools would be vested in a Board of Regents, consisting of the Surgeon General, Public Health Service; Commissioner of Education; Chief Medical Officer, Department of Defense; Chief Medical Officer of VA, ex officio; and six other members to be appointed by the Administrator (salaries of \$15,000 annually). Three of these six would be members of the teaching profession. The Regents would appoint for each school a president, comptroller, dean, and hospital director. Students would be selected on the basis of competitive examinations and their willingness to serve upon completion of their education for a period equal to the period of schooling in either the Department of Defense, VA, Public Health Service, or some other medical agency of the United States or in an area suffering a severe shortage of physicians, selected by the Administrator. Failing to so serve he would be subject to payment of the cost of his education, not to exceed \$750 per year.

Today the group of disease problems associated with adult life has become the dominant problem of public health. Of this disease group, cancer has assumed a position of significance heretofore overshadowed and unrecognized in the traditional fields of public health activities.

the Ca:P ratio is the key

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Gardner, Butler, et al., state: "Relative to human milk, cow's milk has a low Ca:P ratio..."¹ Nesbit writes: "Tetany of the newborn is now recognized as a definite entity... and often accompanied by an increased phosphorus and lowered blood calcium."² Dodd comments that "hypocalcemia tetany in the newborn may be of serious consequence."³

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human milk	Bremil (reconstituted)	
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15 mg.	768 mg.	per qt.
0.15%	.052%	
28 mg.	512 mg.	per qt.
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30 mg.	750 mg.	per qt.
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5 mg.	8 mg.	per qt.

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BREMIL has the fatty acid and amino acid patterns of human milk... the same carbohydrate (lactose)... vitamin adjustments to meet the recommended standards of infant nutrition... a soft, flocculent curd of small particle size comparable to human milk... complete solubility.

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Complete information and a trial supply may be obtained upon request. BREMIL is available in drugstores in 1 lb. cans.

1. Gardner, L. I., Butler, A. M., et al.: *Pediatrics* 5:228, 1950.

2. Nesbit, H. T.: *Texas State J. M.* 38:551, 1943.

3. Dodd, K., and Rapoport, S.: *Am. J. Dis. Children* 78:537, 1949.

4. Recommended Daily Dietary Allowances, Revised 1948, Food and Nutrition Board, National Research Council.

ple, palatable, easy to prepare **Bremil**[®] powdered infant food



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Medical Education -- Your Responsibility, Too

Taking the initiative in raising financial aid for the nation's medical schools, the American Medical Association's Board of Trustees last December announced the appropriation of \$500,000 as the nucleus of a fund to be known as the American Medical Education Foundation. This fund will be distributed among the seventy-nine approved medical schools in the country with "no strings attached." Because the American Medical Association has offered to underwrite all costs of the Foundation, every cent contributed will go directly to aid medical schools.

The fast-growing fund—augmented daily by physicians and others sincerely interested in perpetuating America's medical care system—may forever end the arguments that federal funds are the medical schools' only salvation.

Since the end of World War II, rising costs, decreased income from endowments, and reduced contributions from benefactors have made it difficult for medical schools to make ends meet. It has become increasingly harder to replace old equipment, expand or modernize existing facilities, maintain libraries, and provide attractive salaries to hold competent teachers.

America's medical schools are now operating at or near capacity—enrollments in 1950 reached an all-time high, increasing 6 per cent over the previous year. Michigan, too, reflects the upward trend in enrollments. At the University of Michigan Medical School, Ann Arbor, enrollments climbed from 493 in 1949-50 to 523 in 1951. At Wayne University Medical School, Detroit, enrollments for 1950 and 1951 remained constant at 255. To increase enrollments further, U. S. medical schools must either expand facilities or decrease standards of medical education.

For the past half-century, the AMA has worked unceasingly to raise medical education standards. Improved medical education accounts in a large measure for the tremendous advances in medical care and health standards in the last two decades. Even now the AMA through its Council on Medical Education and Hospitals, spends a quarter of a million dollars annually to advance medical education.

Our medical schools need additional financial support to continue to provide the American people with more and better physicians and to assure continued advancement of the nation's health.

Michigan medical leaders, well aware of the crucial situation confronting the state's own medical schools, in 1950 passed resolutions favoring "any reasonable means to increase the number of medical students graduated" and continued increased efforts to "gain further funds from the Michigan legislature and from the people of the state." The Society worked successfully with Wayne University to secure from the legislature a grant to develop plans for a Medical Science building, and to obtain a grant for a Medical Center building for the University of Michigan.

The AMA opposes the federal aid to medical education bills which are now before Congress. In their present form, these bills will result in federal control of medical education in the United States. It is true, however, that medical schools need financial assistance for construction of new facilities and renovation of existing physical plants. The Association, therefore, has suggested legislation similar to the Hill-Burton Hospital Construction Act, which would provide a one-time federal grant with local control for such expansion and modernization.

The AMA's two-pronged program—free voluntary funds for assistance in operation, and federal funds for assistance in construction—should meet the financial needs of the medical schools, while at the same time preserving their academic freedom.

Because the medical profession has traditionally taken much of the responsibility for the training of young doctors on which it depends for recruits and replacements, it must participate effectively in raising private funds for medical schools.

Every physician recognizes his debt to the medical schools with which he has been associated. Medical graduates, even though they have paid full tuition, contributed only 25 to 50 per cent of the cost of their education to the medical schools. Although many physicians have discharged this debt to society in full or in part by public and charitable activities and by donations to schools, all doctors will want to share in the responsibility of making the Foundation a success.

AMA President, Dr. E. L. Henderson, says: "We must make it clear that the profession is not indifferent to these (medical education) problems.

(Continued on Page 468)

Wyeth



Some Peptic Ulcer Patients Do Better on Phosphaljel

Clinical experience confirms that certain types of difficult-to-manage ulcer show a more striking and lasting response to PHOSPHALJEL therapy than to other types of medication. Palatable PHOSPHALJEL is the peptic ulcer medication of choice in the following conditions:

- Marginal or jejunal ulcer following gastrojejunostomy.¹
- Ulcer complicated by deficiency of pancreatic secretion or by diarrhea.^{1,2,3}
- Prophylactically, after peptic ulcer surgery, and during seasonal recurrence.³

PHOSPHALJEL quickly relieves pain and promotes healing. Excellent for oral therapy, and for intragastric drip therapy.



1. Fauley, G. B., Freeman, S., Ivy, A. C., Atkinson, A. J., and Wigodsky, H. S.: *Arch. Int. Med.* 67:653, 1941.
2. Upham, R., and Chaikin, N. W.: *Rev. Gastroenterol.* 10:287, 1943.
3. Collins, E. N.: *J. A. M. A.* 127:890, 1945.

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(Continued from Page 466)

Let us face our obligation individually and collectively to provide significant financial assistance to medical schools." Dr. Henderson stressed that without strong medical schools, the future capacity of the profession itself to serve society will be in jeopardy.

To make the Foundation an effective force for the maintenance of medical education, it is suggested that each physician consider an annual contribution of \$100. Contributions already received exceed this amount in many cases. But a doctor who finds a \$100 contribution beyond his means can still demonstrate his support with a smaller one. Blanks for submitting contributions appear regularly in the *Journal of the American Medical Association*.

A physician who wishes to earmark his money for a specific school can do so. The Commissioner of Internal Revenue has been asked to rule that contributions will be deductible for the computation of income taxes.

It is hoped that physicians' contributions to the Foundation will stimulate other professions, industries, businesses, labor groups and private donors to contribute to the advancement of the interests of medical education and public health. To the original \$500,000, appropriated from the AMA National Education Campaign, have already been added such sums as a \$100,000 contribution

from the California State Medical Association, and individual gifts ranging up to \$1,000 and over from members of the profession and other groups.

Plans now call for the first disbursement of funds in June. If the contribution is to be an effective one, substantial funds must be forthcoming within the next few weeks. The medical schools will be entirely free to determine how they best can use their share to improve the basic training of medical students.

The Foundation is chartered as a not-for-profit corporation under the laws of Illinois to receive contributions from physicians and friends of the medical profession. It is administered by an eleven-man board of directors chosen from the AMA Board of Trustees, officers of the Association, and the Council on Medical Education and Hospitals. Dr. E. L. Henderson was unanimously elected Foundation president at the first annual meeting in February.

Plans are now being completed to form Foundation committees within the fifty-three constituent state and territorial medical societies as well as within each county and district medical society. These committees will canvass the physicians in their own areas for funds.

It's up to every doctor in the United States to toss a financial life preserver to the nation's struggling medical schools.

Editorial Comment

MEDICINE DID ALL RIGHT EVEN BEFORE MR. EWING

In the *American Federationist* (December, 1950, issue) Federal Security Administrator Oscar Ewing took a swing from the floor at the American Medical Association and the horrid deficiencies of American medical care. Along toward the middle of the piece Oscar bursts out with: "We have made great strides in the past fifty years in reducing the toll of disease. The average child born this year can look forward to about twenty years longer life than one born in 1900."

Whom does Oscar mean by "we"? Surely not the denizens of the nefarious system of private medical care which he has just been telling off

as definitely no good! Or are "we" the politicians and bureaucrats who have been urging the country to give up a system which has prolonged human life by twenty years in exchange for something which up to now hasn't done much more than make human life not worth prolonging?

And that floating "we" isn't the only pronoun that Oscar kicks around. A little later in the article for the AFL house organ he explains that "it" has "provided Federal funds to help states and communities build new hospitals and health centers." If you think "it" refers to the taxpayer, who really does provide the fund, you're wrong. By "it" Oscar meant the Hospital Survey and Construction Act. Naturally.—Editorial, *Saturday Evening Post*, March 31, 1951.



cut to shape . . . Gelfoam*, the absorbable gelatin sponge developed by Upjohn research workers, may be cut to any desired shape and size for control of capillary bleeding. This easily applied and rapidly acting hemostatic agent is valued for solving the problem of oozing in every field of surgery.

For clinical convenience, Gelfoam is supplied as a sterile sponge, pack and cone.

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Cancer Comment

SOME UNSOLVED PUBLIC RELATIONS PROBLEMS

Public relations are assuming increasing importance in the medical field. Many local medical societies are establishing committees to hear and adjust complaints of dissatisfied patients. These complaints most often refer to medical fees and similar economic problems and their satisfactory solution makes for continued friendly relations.

In the cancer field, there is an important unsolved problem in public relations that only the physician and his own conscience can correct. For the past fifteen years or longer, the public has been told the only hope of saving the lives of cancer patients is by periodic examination and early and adequate treatment. Many people acting on this advice go to their physicians and are met with the cynical statement that their cancer fears are groundless and jokingly told to go home and forget about cancer with no attempt at a physical examination to satisfy the patient's interest.

The tragedy of such professional attitudes is that these patients make no further effort at self-protection and, if and when cancer strikes some of them, they delay because of unwillingness to again face the ridicule of their physicians.

Although but a small percentage of the profession is open to censure on this score, physicians indulging in such tactics cause suspicion to be cast on the ability of the entire medical profession to recognize cancer and their interest in doing anything about it.

What is of greater danger is the patient who seeks medical assistance for definite symptoms and receives the wrong advice or is the victim of half-hearted attempts at diagnosis. The following questions cover experiences taken from a long list of reports where the examining physician either did not complete the examination or suggested treatment without thought of cancer. In every case the proper examination would have discovered the malignant growth.

Why do some physicians watch lumps in the breast to see what will happen?

Why do some physicians call an enlarged supraclavicular lymph node a fatty tumor without examining the breast?

Why do some physicians attribute irregular and copious vaginal bleeding to the menopause in patients of that age and make no pelvic examination?

Why do some physicians cauterize cervical "erosions" and not take biopsies of such areas?

Why do some physicians prescribe sex hormones without first making a careful pelvic examination?

Why do some physicians accept the patient's word for hemorrhoids and prescribe suppositories without a rectal examination?

Why do some physicians remove dark moles with acid and the electric cautery?

Why do some physicians treat men for urinary retention without examining the prostate?

Why do some physicians prescribe for persistent indigestion without an x-ray examination of the stomach?

Why do some physicians treat soreness around a joint, especially in a child, for rheumatism without an x-ray examination?

Why do some physicians treat a persistent cough without further examination—especially an x-ray examination of the lungs—to detect the reason for the cough?

As long as these and similar practices continue, people will be doomed to die of cancer who would have been saved if the obvious and proper diagnostic and treatment procedures had been employed.

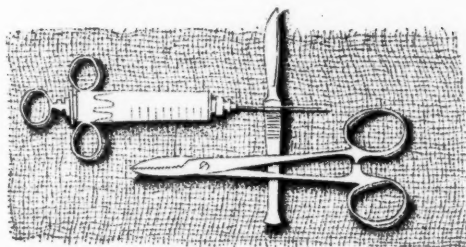
Every speaker on cancer to lay groups learns of these experiences at first hand; they are not day dreams. They constitute one of the greatest obstacles to effective lay cancer education yet encountered. Many people are seriously and intelligently interested in protecting themselves against cancer. People who are rebuffed in their desire for self-protection by means of the medical examination and those who suffer from incurable cancer because of the wrong or neglected diagnosis, do not enhance public respect for the physician's professional ability. Such professional attitudes swell the number of cancer patients who patronize quacks and cultists. These people at least show an interest in the patient and his problem and impress him with their efforts to solve it. Cancer patients often get a psychological build-up from quacks that

(Continued on Page 474)

*Effective against many bacterial
and rickettsial infections, as well as certain
protozoal and large viral diseases.*

AUREOMYCIN

Hydrochloride Crystalline



The Surgeon is no longer hampered in his work by the fear of uncontrollable postoperative infections, thanks in large measure to the sulfonamides and the antibiotics. Aureomycin is indicated for preparation of the gut before enteric surgery. The high concentrations attained by aureomycin in the bile make it of particular value in operations on the infected biliary tract. Its efficacy against streptococci and staphylococci, which are becoming increasingly resistant to penicillin, renders its use advisable in surgical conditions where these organisms are actual or potential invaders.

Packages

Capsules: Bottles of 25 and 100, 50 mg. each capsule. Bottles of 16 and 100, 250 mg. each capsule.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. distilled water.

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Industrial Health Day Successful

Several hundred industrial physicians and surgeons and others interested in the problems of health in industry gathered in Detroit, April 4, 1951, to celebrate the Second Michigan Industrial Health Day. The all-day session was held in the Rackham Memorial Building with Carl Hanna, M.D., Detroit, acting as General Chairman.

The 1951 meeting was sponsored by the Committee on Industrial Health of the Michigan State Medical Society, the Michigan Association of Industrial Physicians and Surgeons, University of Michigan Medical School, Wayne University College of Medicine, University of Michigan School of Public Health, Division of Industrial Health of the Michigan Department of Health, Michigan State Association of Industrial Nurses and the Michigan Industrial Hygiene Society.

The program featured scientific papers by Harry E. Mock, Jr., M.D., Department of Surgery, Northwestern University; Miss Helen DeCoursey, R.N., Kelsey Hayes Wheel Co., Detroit; Alfred W. Pennington, M.D., E. I. Dupont Co., Wilmington, Delaware; Oscar A. Sander, M.D., Marquette University College of Medicine, Milwaukee, Wisconsin; Robert C. Page, M.D., Standard Oil Company of New Jersey, New York, N. Y.; George A. Hardie, M.D., Assistant to the Chief of Medical Branch, U. S. Atomic Energy Commission, Washington, D. C.; James H. Sterner, M.D., Eastman Kodak Co., Rochester, N. Y., and Homer S. Myers, Radioactive Products, Inc., Detroit, Michigan.

The annual banquet was highlighted by an address by Dr. Lillian M. Gilbreth, Consulting Industrial Engineer of Montclair, New Jersey, mother in the best sellers "Cheaper by the Dozen" and "Belles on Their Toes." Dr. Gilbreth spoke on "The Industrial Worker's Better World."

Quarter Century Club Formed

C. E. Umphrey, M.D., Detroit, President of the Michigan State Medical Society, presided as toastmaster at the banquet which also featured the inauguration of the Twenty-five Years Occupational Health Service Group. Joseph L. Zemens, M.D., Detroit, retiring President of the Michigan Association of Industrial Physicians and Surgeons, presided over the organization ceremonies and

presented silver medals to the following leaders of Michigan's industrial medicine during the last quarter century:

A. L. Arnold, M.D., Z. B. Bennett, M.D., H. S. Brown, M.D., C. J. Carpenter, M.D., G. B. Carpenter, M.D., C. A. Christensen, M.D., C. S. Clarke, M.D., Henry Cook, M.D., R. H. Denham, M.D., C. L. DeVries, M.D., C. H. Eisman, M.D., W. L. Finton, M.D., C. B. Gardner, M.D., L. C. Harvie, M.D., L. E. Irvine, M.D., Harley Krieger, M.D., D. F. Kudner, M.D., V. S. Laurin, M.D., A. F. Lecklider, M.D., C. P. McCord, M.D., E. G. Merritt, M.D., J. D. Miller, M.D., D. W. Patterson, M.D., G. C. Penberthy, M.D., A. E. Pullon, M.D., H. J. Pyle, M.D., J. E. Rosenfeld, M.D., C. D. Selby, M.D., L. E. Sevey, M.D., M. R. Sutton, M.D., C. A. Teifer, M.D., G. M. Waldie, M.D., A. H. Whittaker, M.D.

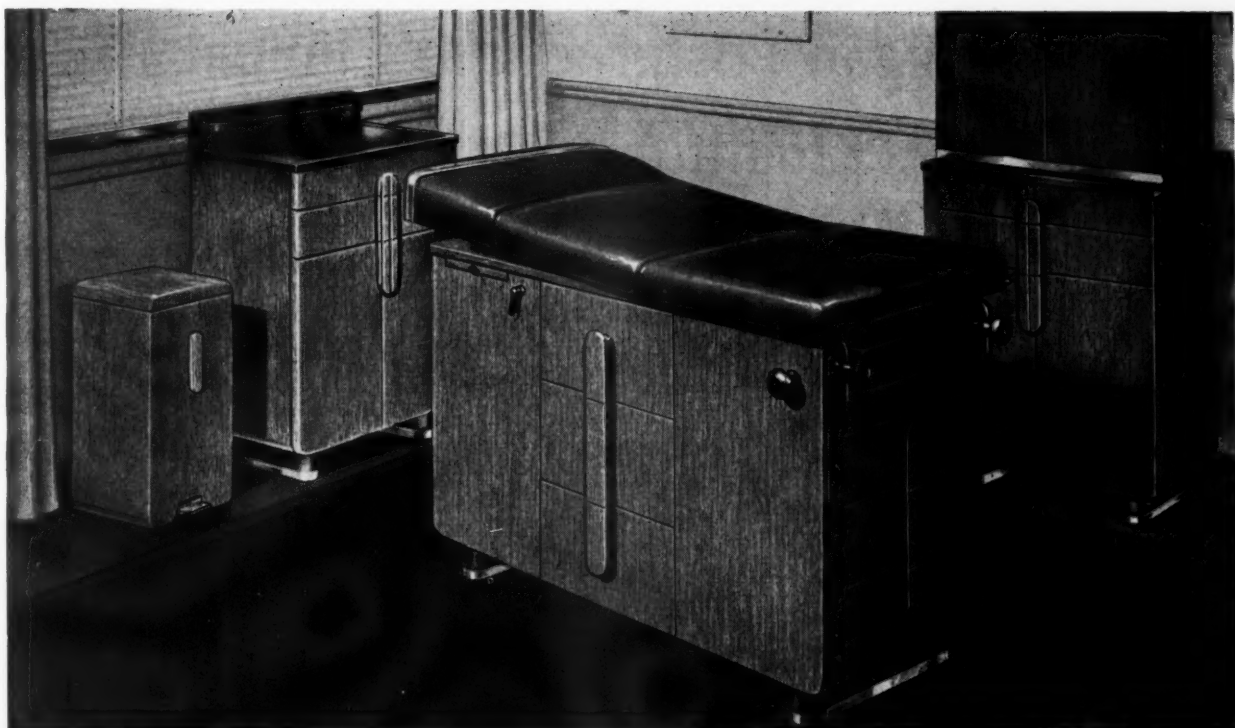
Other M.D. registrants at the April 4 Industrial Health Day were:

Registrants.—Drs. Ira Avrin, Clarence Baker, Donald Ballard, T. I. Boileau, H. J. Brisbois, A. L. Brooks, H. S. Brown, M. R. Burnell, J. E. Caldwell, C. J. Clark, R. G. Colyer, W. T. Cooper, W. A. Dawson, Edwin DeJongh, P. E. Derleth, L. C. Donnelly, G. A. Eadie, W. J. Fulton, L. W. Galley, J. H. Ganschow, J. L. Glee, P. L. Gradolph, G. L. Hagman, W. D. Hall, Carl Hanna, G. A. Hardie, S. L. Hileman, D. V. Holman, E. C. Holmblad, W. L. Howard, T. H. Hunt, E. A. Irvin, K. T. Johnstone, O. J. Johnson, C. H. Keene, W. J. Kemler, D. J. Kilian, H. J. Krenlen, J. L. Krieger, D. F. Kudner, R. C. Leacock, T. E. Lewis, E. F. Lutz, O. T. Mallery, L. R. Martin, W. O. Martin, J. F. McCahan, F. B. McMillan, H. E. Mock, Jr., P. J. Oschsner, D. W. Patterson, E. H. Place, L. I. Powers, O. J. Preston, A. H. Price, F. A. Pumford, P. B. Rastello, A. S. Rogoff, T. I. Roth, A. D. Rush, O. A. Sander, N. W. Scholle, G. H. Scott, M. W. Shellman, Max Silverman, A. R. Sirna, W. J. Smale, S. D. Steiner, H. L. Stern, A. B. Thompson, R. S. Van Harm, V. H. Weidher, E. E. Weston, R. D. Wigent, H. W. Woughter, J. L. Zemens.

Additional Registrants—Don Fowler, A. E. Frazho, Wm. G. Fredrick, S. L. Salsinger.

WE AGREE

"Without physicians, there can be no hospitals. Without physicians, there can be no competent medical care. . . . It is important to bear in mind that nothing should be permitted to interfere with the physician and the control of his professional service. No authority, hospital or other, can direct the physician's professional service to his patient. Hospitals do not, and should not, practice medicine. This must remain the prerogative of the physician."—*Journal of the American Hospital Association*, November, 1950, page 60.



some things are Hard To Describe

Some advertisements are more difficult to write than others. What words, for instance, will tell you how handsome, yet how practical, Hamilton Colortone examining room equipment is? We can say— . . . that any of the four distinctive new Colortones brings a gracious note of color to your examining rooms.

. . . that Colortone retains and enhances all the warmth and richness of fine, selected natural wood grains—hand-finished to perfection by Hamilton Craftsmen.

. . . that Colortone brings new beauty to the color scheme in any office.

. . . that Hamilton equipment embodies 28 separate work-designed features to make your every office hour more pleasant and productive.

Yet, we'll have to rely on your own judgment and alertness to recognize that Colortone is a genuine innovation. Be sure to see our display of Colortone equipment soon.

For natural beauty it's Colortone . . . by Hamilton, of course!

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Michigan Postgraduate Clinical Institute -- 1951

The registration at the 1951 Institute in Detroit totaled 1,579 with the following breakdown:

Doctors of Medicine.....	1,001
Guests	266
Exhibitors	312
	<hr/> 1,579

Out-of-Michigan M.D.s who registered included physicians from Arizona, Australia, California, Canada, District of Columbia, Illinois, Indiana, Massachusetts, Minnesota, Missouri, New York, Ohio, Pennsylvania and Wisconsin.

A total of 32,418 lines of publicity appeared in Detroit and Michigan newspapers in connection with the 1951 MPCl.

What They Thought of the 1951 MPCl and Heart Day

Allan C. Barnes, M.D., Columbus, Ohio (Guest Essayist): "Could I express my appreciation to you for the exceedingly kind treatment I received while at the Michigan Postgraduate Clinical Institute. It was a great pleasure to meet you personally; I thought the programs very enjoyable and the entire session very well organized."

David A. Boyd, Jr., M.D., Rochester, Minnesota (Guest Essayist): "Regarding the Michigan Postgraduate Clinical Institute: it was a very great satisfaction to be at this meeting and I found your organization most generous and kind hosts. I wish to thank you for your courtesy in inviting me to attend this Institute, and I sincerely hope that my paper was of some help to your audience."

Stanley Gibson, M.D., Chicago, Illinois (Guest Essayist): "I have returned from the meeting in Detroit and it was indeed a very pleasant visit. My host, Dr. Nolting, looked after me every minute during my stay and I certainly appreciated his kindness. I also appreciated the very nice greeting from the Michigan Postgraduate Clinical Institute which consisted of a basket of fruit which was sent to my room. That is my first experience of this kind."

Francis D. Moore, M.D., Boston, Mass. (Guest Essayist): "I want to thank you for your kindness and hospitality on the occasion of my visit to the Michigan Postgraduate Clinical Institute. I was treated royally and feel that you did a fine job with your visitors."

Captain G. N. Raines, M.C., USN, Washington, D.C. (Guest Essayist): "Thank you very much for your letter of March 19. I appreciate the opportunity to participate in your program, which I thought was excellent throughout. Please accept my thanks for your kindness during my stay there, and especially for the hospitality shown me by my 'Ubiquitous Host,' Dr. Raymond W. Waggoner."

John G. Bielawski, M.D., Executive Secretary, Michigan Heart Association: "It is my distinct privilege to thank you, in the name of the Michigan Heart Association and its officers, for your splendid co-operation in making possible the Second Annual Michigan Heart Day. I wish also to transmit my personal thanks for having made our exhibit possible. Response to the exhibit was extremely gratifying. It went a long way toward making clear to the physicians of Michigan that we offer no direct medical care to the patient but only help in interpreting the physician's recommendation of "take it easy," on a practical, concrete basis for the housewife afflicted by heart disease. I am looking forward towards working with you next year in what will be the Third Annual Michigan Heart Day."

CANCER COMMENT

(Continued from Page 470)

carries them along for weeks or months of more comfortable living.

Is there not some way to interest *all* physicians to exert every proper effort to get the correct answer to their patients' cancer problem? The affirmative answer to this question will go far toward bringing about a better program of cancer control and a more friendly feeling for the medical profession.

When the dieter prepares the family fare

By curbing the appetite and elevating the mood, DESOXYN Hydrochloride helps to fortify the patient's resistance to constant temptation. Compared with other sympathomimetic amines, DESOXYN is more potent, weight for weight, so that smaller doses may be used effectively. One 2.5- or 5-mg. tablet before breakfast and another about an hour before lunch are usually sufficient to still the pangs of hunger. With DESOXYN you can expect a low incidence of side-effects plus faster action and longer effect than with other sympathomimetic amines. Try it. **Abbott**



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2.5 and 5 mg.

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AMPOULES

20 mg. per cc.

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Military Medicine

SELECTIVE SERVICE SYSTEM

Information Bulletin Vol. 1, No. 4

This is the fourth of a series of Information Bulletins which will be issued periodically for the guidance and information of State and Local Advisory Committees. Should a reasonable amount of additional copies be desired, they can be obtained on request to the above address.

ITEM I STATEMENT CONCERNING POLICY OF NATIONAL ADVISORY COMMITTEE TO SELECTIVE SERVICE ON DEFERMENT OF HOSPITAL RESIDENTS DURING 1951.

In order to meet the needs of the Armed Services practically all the physicians, dentists and veterinarians in Priorities I and II will need to enter service in the relatively near future. How soon the last of them will be required is impossible to state at the present time. But according to the law Priority I must be exhausted, either by call to active military duty or by Selective Service deferment, before individuals in Priority II, except for those who volunteer for immediate active duty, can be called.

There are, however, within Priority II, and even within Priority I, a few individuals who should be deferred because they are essential for teaching, for research, for public health services, or because they are rendering essential medical or dental services in isolated communities. It is the intent of the Selective Service Law that such individuals be deferred until replacements for them can be secured. However, the number of these deferred should be very few and should constitute rare exceptions to the general rule.

To meet the *currently projected needs* of the military service for medical and dental officers, the great majority of physicians and dentists in Priority I will need to be on active duty within six to nine months. To accomplish this, all interns in Priority I will need to enter service at the completion of their internships, and should obtain commissions in advance of that date. The only justifiable exceptions are those interns who are accepted for residencies in the scarcity specialties and whose services are required to meet minimum essential needs of medical and dental schools or hospital services. These *scarcity specialties* for the purposes of deferments are *anaesthesiology, physical medicine and rehabilitation, psychiatry, radiology, neurology, pathology, public health, orthopedic surgery, oral surgery* and the *basic medical sciences*. Deferments that will permit an individual to complete one or two years of training in these areas will provide the military services with individuals who have some training in needed specialties and at the same time will help to meet the minimum essential staff needs of certain hospitals, teaching service, and health department.

Of the other physicians and dentists in Priority I, that is, those who are in hospital residencies, in practice, or

serving in other civilian capacities, the great majority will also be needed in the immediate future.

For the few individuals in these groups for whom indeterminate deferment is necessary, such deferment should be given as a II-A classification by Selective Service upon the recommendation of the National Advisory Committee.

All others in Priority I should seek commissions without delay. Then, if postponement of call to active duty is subsequently justified, this should be accomplished by recommendation for the State Advisory Committee through appropriate military channels.

The above policies will make it necessary for the hospitals to fill their residency appointments almost exclusively from individuals in Priorities II and, preferably, III and IV.

In spite of the fact that individuals in Priority II are not obligated for immediate service, most interns, as well as residents in this priority, will be well advised to seek commissions, upon completion of their internships or residencies, since their services will probably be needed in the relatively near future.

An over-all estimate as to the number of individuals who should be available to serve as hospital residents next year indicates that this total will probably be about 75% of the residents presently serving in hospitals. This over-all situation should be kept in mind by hospital administrators in making their plans for house appointments for the coming year.

DOCTOR SHORTAGE DEPLORED

A West Virginia Democrat, Rep. Cleveland M. Bailey, took the House floor last week to deprecate insufficiency of medical personnel in Veterans Administration to permit proper staffing of VA hospitals. Six new ones are completed but unopened for lack of doctors, he said, and 26 more will be ready for occupancy before the end of this year, requiring an additional 460 medical personnel. "I want to make the prediction that unless something is done in the draft legislation that is about to be considered by the House to exempt doctors who are on the staff of veterans' hospitals, more veterans' hospitals will be closed by the end of this year," he said.—WRMS, January 29, 1951.

DRAFT-DOCTORS

The *Washington Post* for January 24, 1951, stated that the Department of Defense will soon issue an order freezing all commissions for draft-liable physicians at the rank of First Lieutenant, lowest officer rank in the medical corps. "This action will be followed by a second freeze, around the middle of May, banning all further commissions for draft-liable physicians. . . . The Department of Defense intends to bring every one of the 4,813 physically fit Priority I physicians into uniform by July 1, 1951 . . ."

Rectal palpation gives an accurate diagnosis in 80 per cent of prostatic cancer. A poorly defined and non-tender nodule is always suggestive of malignancy in this tissue.

The JOURNAL

of the Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOLUME 50

MAY, 1951

NUMBER 5

Obstruction of the Common Bile Duct by Stones

By Warren H. Cole, M.D.
Chicago, Illinois

IN REALITY, stones in the common duct are a complication of cholelithiasis. It is my impression that at least 80 per cent of stones found in the common duct form in the gall bladder and drop from the cystic duct into the common duct as small stones. A great majority of these small stones pass through the sphincter of Oddi into the duodenum. Some, however, do not pass through the sphincter of Oddi, and remain in the common duct, with subsequent growth. We have fairly good evidence that a small proportion of stones found in the common duct actually are formed there, either in the intrahepatic or extrahepatic duct. We have fairly good evidence of this, insofar as all surgeons have seen at least a few patients who have had choledochostomy on several occasions for removal of stones in the common duct. The fact still remains, however, that the majority of stones found in the common duct subsequent to an operation for removal of stones are probably residual stones left by the surgeon, and not newly formed ones.

Stones are found in the common duct of 15 to 20 per cent of patients having cholecystectomy for cholelithiasis. This percentage will be higher in charity patients than in private patients. As a matter of fact, a survey¹ made in our hospital (which is charity) about ten years ago revealed that 22 per cent of patients having cholecystectomy for cholelithiasis had stones in the common duct. It is well known that fully 25 per cent of

stones found in the common duct are not associated with a previous history of jaundice.

Contrary to the usual impression among clinicians that stones are not encountered in acute cholecystitis, statistics reveal that they do occur under these circumstances. For example, in a series of 697 patients operated upon for acute cholecystitis, Glenn² reported performance of choledochostomy alone after cholecystostomy or cholecystectomy in 8.5 per cent of cases. Stones were found in 66 per cent of this group having choledochostomy.

Important Points in Differential Diagnosis

It should be emphasized that the establishment of an accurate diagnosis is extremely important, but nevertheless may be very difficult on certain occasions. The importance of accurate diagnosis can readily be appreciated by the fact that operation is obviously strongly contra-indicated in virus hepatitis. As a matter of fact, operation in such patients may actually result in death of the patient.

The first symptom complained of by patients with jaundice due to stone in the common duct is usually pain located in the right upper quadrant or in the mid-epigastrium, perhaps to the right of the midline. This pain commonly radiates posteriorly toward the midline. For a day or so this pain is severe, but gradually lessens and commonly disappears completely, even though obstruction is complete. Within forty-eight hours after onset of the pain, itching and jaundice appear. Although the first stool may be of normal color, subsequent stools are acholic so long as the obstruction remains complete. Accompanying the pain in the initial stages of the disease, nausea and vomiting are common but the latter is by no means constant. Muscle spasm is usually not present, but occasionally may be present, particularly in the

¹From the Department of Surgery, University of Illinois, College of Medicine.

right upper quadrant or right epigastric. Fever is present only in cases complicated by infection of the suppurative cholangitis type. If the patient has been jaundiced for several days, bleeding from the gums or gastrointestinal tract are occasionally encountered, but only rarely will it be serious.

Hepatogenous Jaundice.—Patients with this disease must be identified and differentiated from those with stone in the common duct because of the deleterious (and sometimes fatal) effects of operation. The two most common types of hepatogenous jaundice are virus hepatitis or infection of the epidemic type, and homologous serum jaundice. In the former group of patients there is commonly a history of contact with another patient with similar symptoms three to four weeks previously. In the latter group, that is, homologous serum jaundice, there is frequently a history of a needle puncture (with an unsterilized needle) or a transfusion 60 to 120 days previously.

The history is similar in either of the two conditions enumerated above. The first symptoms are weakness and anorexia, followed in two or three days by jaundice. It should be emphasized, however, that these two diseases probably do not progress to the stage of jaundice in the majority of cases. In severe cases, stools are cholic for several days, after which time they become acholic, even though jaundice persists. Contrary to general opinion, itching is fairly common in jaundice of this type.

Acute or subacute atrophy of the liver is a very serious condition, usually fatal, with onset similar to virus hepatitis, but with symptoms usually more pronounced. Although the liver may be enlarged in the early stages of this disease, it decreases in size on most occasions until it is not palpable. In any type of severe acute hepatic insufficiency of the hepatogenous type, spider naevi are occasionally encountered. When these naevi are multiple, they are of great significance diagnostically, particularly if they have developed only since symptoms developed. On many occasions, a musty aromatic odor (feto hepatis) will be detected. As emphasized by Watson,⁴ this odor is in reality quite characteristic and, in fact, may be pathognomonic of severe hepatic disease.

Carcinoma of the Pancreas.—In about 80 per cent of patients this lesion develops without pain; weakness and anorexia are the first symptoms.

Jaundice and occasionally itching occur in a few days. An important feature about the diagnosis of carcinoma of the pancreas lies in the fact that once jaundice develops and stools become acholic, there is no recession in these symptoms. In the later stages of carcinoma of the head of the pancreas, the jaundice may have a greenish hue to it, especially in the cachectic stage of the disease. One of the most diagnostic features of carcinoma of the head of the pancreas is an enlarged, non-tender gall bladder, which usually, but not always, can be palpated. This large gall bladder, contrasted to the small shrunken gall bladder in a patient with stones in the common duct, is extremely valuable diagnostically, as was brought out by Courvoisier a number of years ago.

Carcinoma of the Papilla of Vater.—In many ways, this lesion produces symptoms similar to stone in the common duct, although pain is usually less prominent. Intermittency of jaundice and acholic stools is fairly common because of necrosis of tumor at the duct outlet. Very important in this diagnosis is the fact that occult blood can usually be found in the stool. In advanced cases fluoroscopic examination with barium will reveal a deformity of the duodenum.

Hemolytic Jaundice.—Symptoms are insidious in this condition, or in fact, often absent. Jaundice itself may develop early in life and is usually intermittent in type. Commonly there is a history that other members of the family have a similar type of jaundice. The stool is of normal color. A large amount of urobilinogen is found in the urine, but no bilirubin. A large spleen can be very helpful in the diagnosis of this condition.

Stricture of the Common Duct.—Symptoms are quite variable in stricture of the common duct, but in 70 to 75 per cent of patients there will be a previous history of cholecystectomy. Pain is variable but on most occasions is present in at least a slight degree although occasionally there is very profuse pain in the upper abdomen. At the onset of stricture, the jaundice is commonly intermittent in type and usually associated with chills and fever.

Value of Liver Function Tests.—There are several liver function tests which will be of great help in differentiating hepatogenous jaundice from extrahepatic obstruction. In this group may be

mentioned the urobilinogen, thymol turbidity, alkaline phosphatase, and bromsulfalein tests. Urobilinogen may be found in the urine in states of excessive hemolysis and hepatocellular jaundice. However, it must be remembered that urobilinogen will not be found in the urine if complete obstruction of the common duct is present. The thymol turbidity test is of considerable value. Readings above 4 units are considered indicative of the presence of intrahepatic disease. The alkaline phosphatase test is of about equal value, but in a different respect. With few exceptions readings over 10 units are indicative of obstructive jaundice; in normal people and patients with hepatogenous jaundice readings are usually under 10 units.

Ordinarily, liver function tests are normal in all patients with early common duct obstruction without acute hepatic disease. At the onset of jaundice due to obstruction of the common duct by stone, there will be no significant intrahepatic disease. However, if suppurative cholangitis should develop, as indicated by chills and fever, considerable cellular damage with impaired function may result.

Preoperative Treatment

Of vital importance in the treatment of patients with stone in the common duct is the fact that immediate operation is rarely indicated unless a severe suppurative cholangitis exists concomitantly. In fact, it is usually desirable to wait a few days before operation is contemplated, since dilatation of the duct around the stone commonly results in dislodgment of the stone with conversion of complete obstruction to partial or intermittent. Relief of complete obstruction obviously would improve the patient's operability. Of equal importance in the warning about early operation in obstructive jaundice is the fact that an accurate differential diagnosis is so often impossible to make in the first few hours of hospitalization. Since the disease will usually be of recent onset, there will rarely be any severe nutritional deficiency or severe loss in weight. Nevertheless, it is essential to maintain a normal caloric intake, concentrated on a high protein high carbohydrate diet. If the patient is nauseated or unable to take food by mouth, calories would have to be supplied by intravenous therapy, consisting of glucose and amigen along with a small amount of saline. Amigen can be given safely in common duct obstruction but its rate of administration should be reduced somewhat. When jaundice has been pres-

ent for more than a few days, administration of substance having vitamin K action should be introduced to prevent hemorrhage due to vitamin K deficiency. Numerous water-soluble synthetic agents are available for this purpose. The dose of one of these (Hykinone) is 2.5 mg. when injected intravenously, intramuscularly or subcutaneously. In reality, the dosage should be dependent upon the prothrombin level. If considerable hepatic insufficiency exists, the prothrombin level will not revert to normal with such a small dose. Under those circumstances, a large dose, up to 10 to 15 mg. per day, would be required. Failure of the prothrombin time to respond favorably to these drugs is commonly an indication of severe hepatic insufficiency.

Operative Considerations

It is not our purpose to present details of technique in this discussion. Some of the principles in the operation of choledochostomy are illustrated in Figure 1. I wish to emphasize the importance of care in palpation of the common duct, lest a stone be pushed upward into the liver. I had this complication happen to me on one occasion. At the onset of operation, I palpated a stone in the common duct, but without exercising due care, I dislodged it upward into the liver and could not retrieve it by scoops after I had opened the common duct. In this particular case I had to perform a choledochostomy and go back later to remove the stone when I discovered by cholangiography that it had dropped down into the common duct.

To identify the common duct accurately, aspiration with a small hypodermic needle is extremely helpful. Before making an incision in the duct, the exterior should be dissected free to be certain that the right hepatic artery does not cross to the right, anterior to the common duct. After removal of all stones with a gallstone scoop, one must be certain that a probe or scoop can be inserted downward past the sphincter of Oddi. On numerous occasions the end of the probe or scoop can be palpated through the duodenal wall and thought to be within the lumen, whereas in reality it has lodged outside it posteriorly, in the margin of the posterior wall. With very few exceptions the end of the probe or scoop can actually be seen through one layer of duodenal wall, but not through two layers. This visual phenomenon has been a great help to me in being certain

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that my probe or scoop had passed through the sphincter of Oddi.

In a preliminary report by Lampert and associates,³ disintegration of gallstones by exposure

the probe touches it and touches it with more than a slight contact. Under these circumstances of contact, it is usually possible to find stones with a probe or scoop. However, my opinion of the

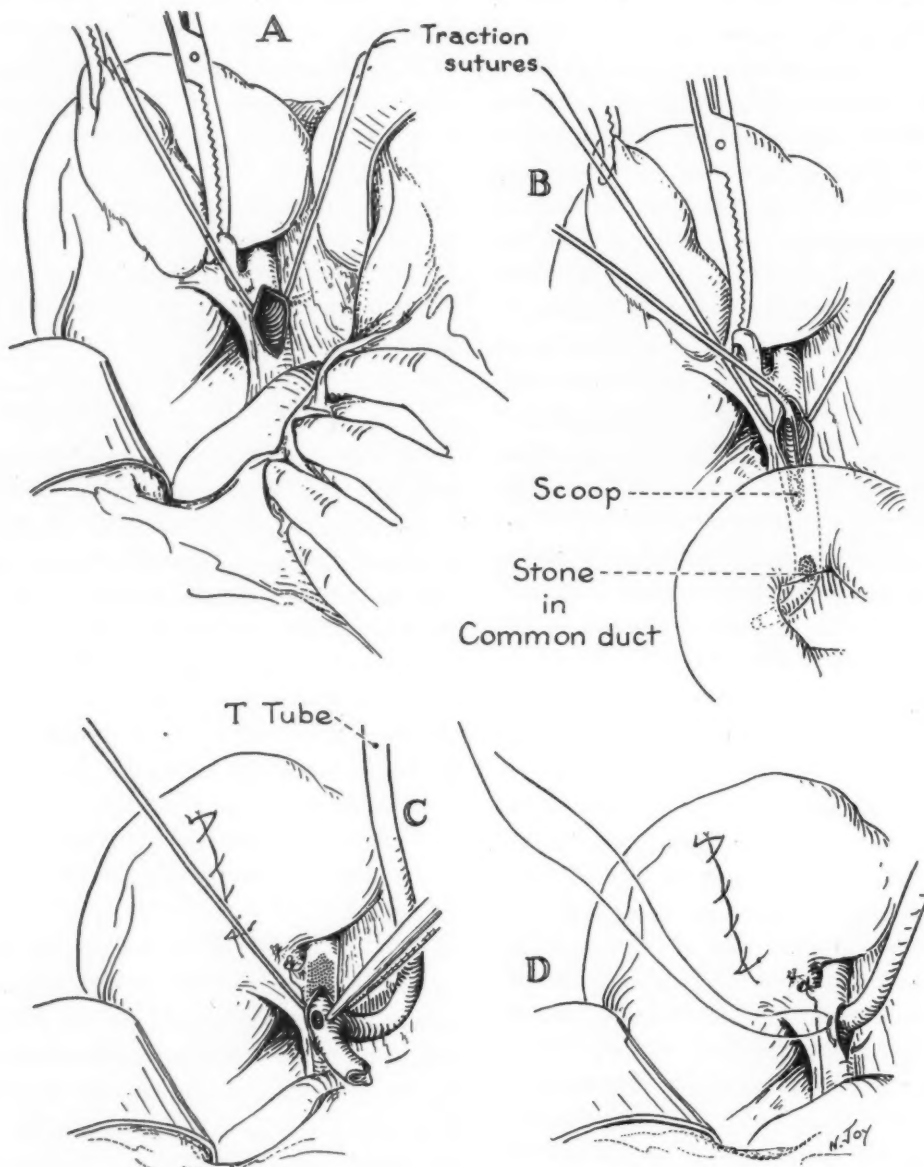


Fig. 1. Choledochostomy for stone in the common duct. (A) The common duct is opened between two stay sutures of fine silk. (B) Stones are removed with the aid of proper scoops. (C) After the stones have been removed a T-tube is inserted. (D) The opening around the tube is closed with one or two sutures of No. 000 plain catgut (From *Operative Technic*. Edited by W. H. Cole. New York: Appleton-Century-Crofts, 1949.)

to the ultrasonic beam for fifteen seconds has been described. Up to date they have tried this method only on animals, but no deleterious effects on dogs have been noted. Two or three types of electronic probes have likewise been described to aid in the finding of stones within the common duct. Conceivably they could be very helpful in finding

value of such an instrument is by no means final since I have not had an opportunity to try any of them.

After the surgeon is convinced that all stones have been removed, a T-tube should be inserted and the opening in the common duct closed around the T-tube with interrupted sutures of

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fine catgut. The wound is closed around this T-tube leaving a soft Penrose drain leading down to Morrison's pouch. The author is aware of the fact that some surgeons close the common duct

removed. The patient should be able to take a regular diet within a day or so after this. One of the synthetic vitamin K-like products should be given daily for five to six days after operation

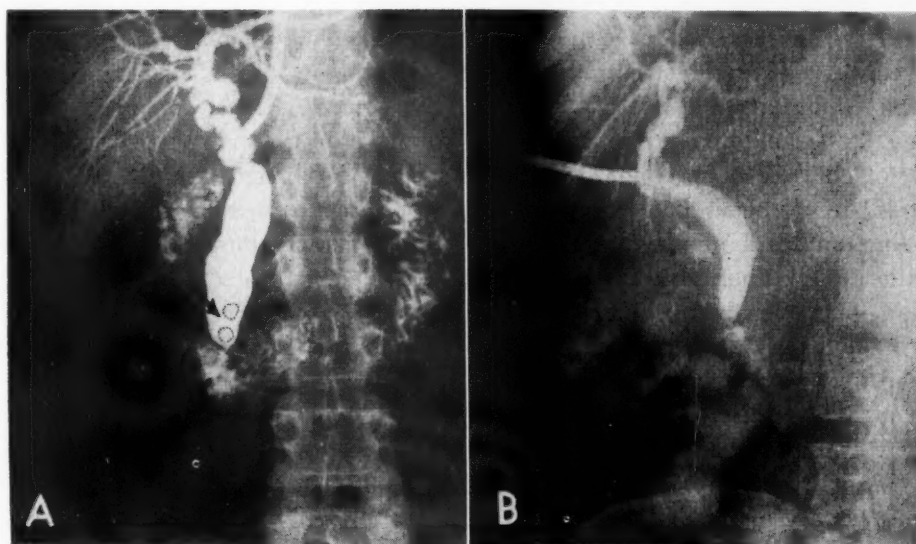


Fig. 2. This patient had a cholecystectomy and choledochostomy with removal of fifty small stones from the common duct. Shortly after operation she developed itching, slight jaundice and had several acholic stools indicating common duct obstruction. (A) Cholangiogram taken three months after operation revealed the shadow of two residual stones in the common duct. The shadows were not visible in the reproduced photographic print but the two dotted circles indicate their size and location on the film. (B) She was placed on bile salts 3 to 5 grams per day and at the time of this cholangiogram (nine weeks after discovery of the residual stones) the shadows are no longer visible. The T-tube was removed a week or two after this cholangiogram. The patient has remained well up to date. It is barely possible that these stones were passed spontaneously, but the author is of the opinion that the bile salts exerted a favorable influence and would recommend their administration under similar circumstances.

without drainage after removal of stones. However, since development of a stricture following implacement of a T-tube in the common duct is practically unheard of, the author prefers to insert a tube, although on a few occasions he has closed out the duct with interrupted sutures. If the duct has been closed without the insertion of a T-tube, there is still more indication for the insertion of a Penrose drain down to this area since any leak of bile might be followed by bile peritonitis or an abscess.

Postoperative Care

Usually the postoperative care in patients having choledochostomy is relatively uneventful. Intravenous fluids would be necessary so long as gastric decompression is carried out, and in the author's opinion this decompression is helpful in eliminating abdominal distention, gas pain, et cetera, if maintained for about forty-eight hours. Oral feedings are resumed as soon as the tube is

in doses equal to 2.5 to 5 mg. per day. More should be given on the day of operation particularly if there has been any prothrombin deficiency.

The author is not a proponent of prolonged drainage of the common duct with a T-tube. On about the tenth day we begin to clamp the tube an hour or two each day, lengthening the period of obstruction from day to day until the patient is able to tolerate clamping of the tube overnight without symptoms. If the stools are of normal color and the patient can tolerate clamping of the tube for twelve to twenty-four hours, it can safely be removed. In the average case, the time of removal would be about three weeks.

Complications of Stone in the Common Duct

The most common and most significant complication of stone in the common duct is suppurative cholangitis. With very few exceptions, patients suffering from this type of infection will complain of chills and fever. Pain may be pres-

ent in the majority of cases, but is not always severe. In addition to chills and fever, other manifestations of infection, including leukocytosis, anorexia, weakness, et cetera, may be present. When suppurative cholangitis appears with stone in the common duct, emergency operation is strongly indicated. On numerous occasions the author has given penicillin and streptomycin to patients with this condition. On not a single occasion has penicillin been observed to exert the slightest benefit or control the infection. On one or two occasions streptomycin has been of distinct benefit. Aureomycin might be slightly more effectual, but the author doubts if chemotherapy will ever supplant operation because chemotherapy can obviously not relieve an obstruction. It would appear entirely reasonable to plan on an operation as soon as operability permits, introducing chemotherapy as soon as the diagnosis is made and continuing it for a few days after operation, depending upon evidence of infection.

As already stated, hemorrhage from the gums or gastrointestinal tract is occasionally observed in patients with obstruction of the common duct by stone, particularly if obstruction has been present for several days or weeks. As stated previously, this hemorrhage will depend upon vitamin K deficiency and is controlled by vitamin K-like products unless the hepatic insufficiency is severe.

A few miscellaneous complications, such as anemia, loss of weight, et cetera, are observed in common duct obstruction, usually only when obstruction has been present for several weeks. Kidney damage and uremia occur, but are uncommon. Bile peritonitis may develop after choledochostomy if leakage of bile from the duct occurs, and no drain was left in to allow for drainage. Even when drains are inserted, care must be exercised in closure of the wound since too tight closure around the drain may not allow free drainage. Pancreatitis occasionally develops as a complication of stones in the common duct; under such circumstances the chronic type is more common than the acute. Absence of bile from the digestive tract, as would take place in complete obstruction, obviously interferes with digestion, but serious malnutrition is rarely encountered except in seriously neglected cases.

The complications which most commonly result in fatalities are hepatic insufficiency and infection. Infection itself may be an important (in fact, the most important) factor in the develop-

ment of hepatic insufficiency. On other occasions, severe hepatic insufficiency may develop without obvious explanation. As stated previously, obstruction of the common duct in the absence of infection produces only slight demonstrable liver damage, for several days at least. Nevertheless, it is unreasonable to expect that a complete retention of bile as would exist in complete obstruction of the common duct, could exist without inflicting damage on the liver. It is very probable that considerable damage is inflicted even though microscopic sections reveal no pathologic changes, and liver function tests reveal no impairment of function. When infection is the primary cause of death, it usually is manifested first as a suppurative cholangitis (secondary to the obstruction), and later develops into multiple liver abscesses; the latter complication of liver abscesses will rarely be encountered in modern times if operative drainage of the common duct is not delayed and chemotherapy is instituted along with operation. It must be remembered that infection may be superimposed on a collection of bile escaping from the common duct into the peritoneal cavity, and likewise that it may develop as the result of massive bacterial contamination at operation, by excessive trauma at operation, or by unwise choice of large suture material.

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Vascular disease is more frequent and severe in diabetics in whom the disease begins in the first or second decade and who survive more than fifteen years than in those with an onset in middle life.

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In prostatic cancer without metastasis, castration or estrogens appear to have equal therapeutic value but the two combined promote increased survival.

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Needle biopsy of the liver is contraindicated in small livers because of possible bowel perforation and in obstructive jaundice because of risk of establishing a bile fistula and bile peritonitis.

Allergic Myalgia

By Theron G. Randolph, M.D.

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ROWE²³ in 1930 was the first to point out the allergic etiology of various muscle aches and pains as a part of the clinical picture of what he termed allergic toxemia. In subsequent publications^{24,25} he continued to stress the importance of such muscle symptoms, citing several case illustrations of painful, aching muscles of the neck, back and extremities as manifestations of the food allergy process. Rinkel²¹ in 1933 mentioned aching of the neck muscles as one of the prodromal features of attacks of migraine due to food allergy. This point of view was first presented by the writer¹⁴ in 1947. Meyer⁷ has subsequently reported myalgias as manifestations of food allergy.

Valleix³⁰ in 1841 mentioned the diet as a precipitating factor in the development of painful aching symptoms occurring in the muscles of the upper back and posterior cervical region. Gudzent⁵ in 1927 expressed the belief that a special group of rheumatic disturbances might be of allergic origin and in 1935 stated that chronic rheumatism was sometimes made worse by the ingestion of specific foods, and that the removal of these foods from the diet resulted in improvement. Curschmann³ in 1937 spoke of nutritional allergies in relation to muscular rheumatism.

The association of muscle symptoms of the posterior cervical region and upper back was correlated with the history of allergic disturbances by both Seydell²⁶ and Williams³¹ but neither traced the muscle responses as manifestations of specific exposure to allergens, both emphasizing the role of physical factors in the pathogenesis of such symptoms. Williams felt that these symptoms were on the basis of a physical allergy and described this as part of the picture of intrinsic allergy. The conception that physical agents were responsible for the precipitation of such symptom syndromes has been observed by many clinicians.^{4,6,8,9,26,30,31}

The allergic response involving skeletal musculature is most commonly localized to the muscles of the posterior cervical region, shoulders and upper

back. Pulling and drawing sensations, tautness, stiffness and aching pain involving the nuchal muscles and occurring both with and without associated headache is a common symptomatology encountered in taking histories in allergic individuals. Myalgia of the posterior cervical muscles has been repeatedly observed by the author to follow the experimental ingestion of foods or exposure to inhalants in specifically sensitized individuals. The fact that symptoms of this type may be reproduced at will under experimental circumstances, that is, following the trial ingestion of allergenic foods or the overdosage of house dust extract or massive dust exposure in dust-sensitive individuals and that such chronic symptoms may be relieved following the avoidance of incriminated ingestant allergens and avoidance or specific therapy in the dust-sensitive patient, is the basis of the thesis that such manifestations are of allergic origin. The relationship of nuchal myalgia and headaches as clinical manifestations of allergy has been presented in another communication.¹¹ Less commonly a more acute allergic reaction involves sharply localized areas in the trapezius or sternocleidomastoid muscles resulting in attacks of acute torticollis or "wry neck"; several cases, in which acute episodes meeting the descriptive feature of acute torticollis have followed the trial or inadvertent ingestion of foods in specifically sensitized individuals, have recently been reported.¹⁰

Similar localized reactions have been observed less frequently in the calf muscles, the hamstrings, the lower muscles of the back, the pectoral muscles, the intercostals and in the rectus abdominus. The following cases were chosen to illustrate the localization of myalgia of allergic origin to these structures.

Case Reports

Case 1.—L. S., a laboratory technician and physician's wife, aged thirty-two, had been subject to intermittent urticaria, seasonal hay fever and asthma since a child with progressively severe perennial allergic rhinitis and bronchial asthma since 1935. Chronic fatigue had been a major symptom for many years.

For at least fifteen years she had complained of intermittent attacks of myalgia of the posterior cervical muscles occurring in association with severe headaches. Individual episodes were characterized by pulling, drawing, tautness and progressive aching of the nuchal muscles, followed by the development of sharply localized tender areas on the upper edges of the trapezius muscles and the subsequent development of a severe generalized headache. The latter occurred in association with an accentuation of her chronic fatigue. These

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attacks usually began on awakening in the morning. They varied in severity and duration from mild episodes not progressing beyond the stage of tautness and aching of the cervical muscles to more severe bouts characterized by progressively troublesome pains and contractures of the nuchal muscles which elevated her shoulder and pulled her head backward and toward the affected side. When present to a similar extent bilaterally, both shoulders became elevated and the neck became hyperextended. The more acute attacks had all the clinical features of acute torticollis, with the exception that she never experienced the sudden and acute onset of neck pain as in the cases of acute torticollis.

Examination during attacks revealed marked firmness and tautness of the trapezius, and the presence of tender, indurated areas along the upper borders of the mid-portion of this muscle. Various degrees of extension of the neck and immobility with lateral fixation of her head existed in proportion to the severity of the symptoms. Gentle massage of the posterior neck, although very helpful temporarily in "loosening" these muscles and alleviating the pain and aching, failed to change the course of the attacks.

For the past fifteen years she also has had intermittent cramps of her legs; these acute attacks were superimposed on a background of constant pulling, aching and drawing leg pains. The sudden onset of acute leg cramps might awaken her at night or make it necessary to drop whatever she might be doing in order to massage the "knots" in the leg muscles. In such acute episodes her husband, a physician, reported the presence of spindle-shaped, exquisitely tender, hard nodules on palpation of the involved muscles. Such indurated areas varied in size from 1 to 3 cm. in diameter and were sometimes as long as 15 cm. The larger knots were observed principally in the gastrocnemius muscles, less extensive involvement occurred in the hamstrings and tibialis anticus. When subject to oft-recurring or continuous muscle symptoms of this type, she was unable to walk up or down stairs and for several days at a time it might be necessary for her to be carried about the house.

There were also less frequent occasions when she would experience the sudden onset of violent pain and sharply localized intercostal tenderness in the mid-axillary line of the right chest. These excruciating pains were associated with profuse perspiration and materially interfered with her ability to breathe but fortunately only persisted for a few seconds. In contrast to the type of pain in pleurisy, the pain of these attacks was only accentuated by expiration. The examination of the chest during such episodes remained negative except for the localized tenderness and the obvious distress of the patient.

Repeated medical consultations and examinations over a period of many years had failed to reveal the cause of these troublesome and frequently incapacitating muscle symptoms. There had been no evidence of an infectious process as evidenced by normal blood counts, sedimentation rates and other laboratory findings. There had been no evidence of mineral or vitamin deprivation or deficiency, and massive doses of calcium and vitamins by various routes failed to alter the course of the illness.

X-rays failed to reveal any evidence of rheumatoid arthritis. Various blood chemistry determinations had been reported negatively.

The first experimentally induced attack of acute myalgia was associated with an individual food test^{16,19} with wheat; experimental ingestion after four days of complete avoidance was followed by a sharp paroxysm of coughing beginning at five minutes, followed by a chill at forty-five minutes and the onset of cramping pains in the leg muscles at fifty-five minutes. Similar leg symptoms developed in association with several other diagnostic individual food tests, the most violent response occurring ten minutes after the test ingestion of eggs. This proved to be one of the most severe muscle reactions that she had ever experienced. Three days were required for the acute symptoms to subside, less severe soreness persisted for several additional days. Less acute muscle symptoms followed the test ingestion of potatoes and of corn, with the development of leg symptoms at fifteen and twenty minutes, respectively.

Additional foods have been incriminated in respect to other allergic symptoms. With the avoidance of the major allergens and the use of those with lesser degrees of sensitivity in spaced feedings, she had no unexplained headaches, neck, leg or chest pains during the past year. On repeated occasions a minimal amount of eggs has reproduced violent muscle symptoms, several times this occurred inadvertently and was discovered in retrospect after the onset of an attack. Potatoes, corn and wheat have been shown to be effective in producing muscle symptoms in the order named, but after several months of avoidance she has regained a sufficient tolerance for these foods that repeated ingestion is necessary to bring about such a response.

Case 2.—E. R., a housewife, aged fifty-three, had been subject to intermittent attacks of pulling, drawing and aching sensations of the cords of the posterior neck for thirty years. Although these episodes varied markedly in intensity, the pain and stiffness of the neck muscles were invariably more pronounced in the early morning hours, usually beginning with the first motion in bed on awakening. Whereas at first the neck symptoms were only occasionally associated with headaches, this relationship became much more common as the episodes increased in frequency and intensity. Her headaches invariably started with myalgia of the nuchal muscles, the aching pains then spread to the frontal region and the more severe seizures were associated with scotomata, photophobia, tinnitus, dizziness, tingling of the fingers, blurring vision, suggestive hemianopsia and extreme fatigue. Sudden motion of her head in any direction increased the dizziness to the point that she commonly fell. Vomiting occurred occasionally.

Her neck had been continually stiff and sore and she had been unable to arise from bed without assistance for a year prior to her first visit in 1946. Her neck remained painful on motion at all times and except for an occasional good day it was limited in the extremes of motion. On frequent occasions, sometimes as often as three times per week, she suffered acute attacks of neck pain superimposed upon this chronic level of myalgia;

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these were usually initiated by a sudden motion of her head such as from turning in her sleep or upon arising from bed; they were characterized by the abrupt onset of excruciating pain localized slightly to the right or left of the spine in the region of the insertion of the trapezius muscle. In all instances the acute pains were limited to areas not larger than 2 cm. in diameter, firm on palpation and exquisitely tender to the point that she was unable to tolerate the weight of overlying clothing. She obtained some relief by taking as many as 100 aspirin tablets per week, maintaining both shoulders in elevated positions with her head bent slightly forward and, at times, wearing a neck brace.

Since the age of eighteen she had also been subject to acute cramping sensations in her feet and calves, for which various types of therapeutic shoes had been prescribed without effect. With the onset of such cramps, she obtained temporary relief by removing her shoes, standing barefooted and massaging her leg muscles. Cramps occurring in the calves were associated with the sudden development of exquisitely painful palpable "knots" in either one or both gastrocnemius muscles. Similar cramping sensations occurred a few times in the hamstring muscles and in the gluteus maximum area.

In recent years she had also complained of a painful, nodular areas occurring in the pectoralis major muscles. Each time such a reaction occurred in the left chest she was alarmed that it was a heart attack but electrocardiograms obtained with a few hours and at intervals of several days failed to reveal any abnormalities. She "blackened" out in two particularly violent attacks affecting the muscles of the anterior chest wall, remaining unconscious for a few minutes each time. On other occasions similar acute pains were localized to sharply limited areas between the ribs; these were so extremely painful and tender that inspiration and expiration were exceedingly difficult.

In addition she had been subject to varying degrees of pain and tenderness of the abdomen for a year prior to her initial visit. This portion of her history, at first difficult to interpret, became more apparent when examination during the more acute episodes revealed the presence of hypertonicity and tenderness on palpitation of segments of the rectus abdominis. She also remained subject to continuous anorexia and intermittent bouts of diarrhea and constipation; these symptoms were not related in timing with the tenderness of the abdominal wall except that occasionally generalized abdominal tenderness would be accentuated after a severe episode of diarrhea.

Although she had been under medical care for over a decade and had been subjected to repeated x-ray examination of the gastrointestinal tract, spine and head, she remained an unexplained diagnostic problem and had been generally regarded as a neurotic both by her physician and other acquaintances.

On allergic investigation she was found to be highly sensitive to house dust and silk, obtaining considerable relief from her respiratory symptoms as a result of specific therapy.

Deliberate individual food tests with corn, wheat, milk, eggs and beef were each associated with sharp clinical reactions. Sensitivity to cottonseed oil and cane as well

as several other minor articles of the diet has been determined during the past two-year period. With the continuation of inhalant therapy, complete avoidance of the foods to which she is most highly sensitive and the use of other articles of the diet in spaced feedings she has remained free of troublesome allergic symptoms.

The effectiveness of various foods in precipitating one or more of the varicose muscle syndromes has been demonstrated repeatedly; this type of reaction not only occurred following the individual food tests with eggs, corn and milk but on each subsequent occasion that these foods were intentionally or accidentally ingested. Following the experimental ingestion of two eggs in April, 1947, after they had been omitted from the diet for the preceding five months, she developed tautness and drawing sensations of the posterior neck muscles at twenty minutes, followed promptly by the development of a severe generalized headache, rhinorrhea and extreme fatigue. After sleeping fitfully the night of the test, she awakened the following morning with marked stiffness and contracture of the nuchal muscles on the right; they remained firm, knotty and extremely tender, interfering with the normal motion of her head for the following three days.

On another occasion she noticed the gradual recurrence of her cervical myalgia and constant headache which persisted for a period of six weeks before it was determined that she was reacting to the cornstarch contained as an excipient in a daily dose of a single tablet of desiccated thyroid. Brief reference to this incident has been made in a previous communication.¹³ With the omission of the thyroid her myalgia and headache subsided but promptly recurred following each attempt to resume this form of the medication. A similar reaction followed the ingestion of standard ferrum reduatum, also known to have contained a cornstarch excipient. In each instance these drugs in tablets known to be free of cornstarch* were tolerated.

After the avoidance of milk for a period of one year, one-half glass was included in the evening meal otherwise containing compatible foods. Within one-half hour she experienced a twinge of pain in the upper mid portion of the right trapezius muscle which was followed by progressive tautness and pulling sensations localized to the right side of the neck. Observation later that evening revealed the presence of an exquisitely tender palpable nodule measuring 3 cm. in diameter in the upper mid portion of the right trapezius in addition to hypertonicity of all the muscle groups on that side of the neck and the tendency to hold the head and shoulders in relatively fixed positions favoring the shortening of these muscles. Three days were required for this attack to subside.

Aside from the deliberate or inadvertent exposure to known food allergens she has remained completely free of myalgia, headache, fatigue and other allergic symptoms, leading an energetic and useful life for the past three

*"Abergic" brand tablets, prepared by the Upjohn Company, Kalamazoo, Michigan, are free of corn and other allergenic foods commonly employed as excipients in pharmaceutical preparations. The problem of allergenic foods in medications has recently been presented by the author.^{12,15}

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years in contrast to the previous ten-year period of chronic invalidism.

Case 3.—C. J., a machine operator, aged thirty-three, was first seen in 1943 because of intermittent low backaches which had been present for the previous decade. Their onset occurred at the time he was employed as a structural steel worker, and they were attributed to the climbing in connection with this job. Although he changed his occupation to that of a machine operator in 1941, he continued to have on the average of two attacks weekly; an episode invariably occurred Sunday afternoon and Monday morning. A typical attack was described as a sense of rawness, generalized tenderness and aching of the muscles of the lumbosacral region occurring in conjunction with pulling, drawing and tautness of the hamstring muscles of both legs. His chronic fatigue was accentuated in association with his backache and leg symptoms and in about half of his attacks he also complained of a dull generalized headache. During these episodes he was told that he was "groggy," listless, irritable and difficult to work with.

In 1939 he began having perennial nasal stuffiness, accentuated each morning and very severe headaches which usually started on Sunday afternoons. The first indication of the onset of a headache was a sense of stiffening of the cords of the right side of the posterior neck and upper back; this was followed shortly by sharp pulsating pains extending throughout the entire right side of his head. Several extensive investigations had failed to reveal the cause of these symptoms; in the presence of normal x-ray examinations of the spine he was told that his symptoms were on the basis of nervousness.

Although he did not suspect any foods, his diet history revealed that he invariably ate chicken every Sunday noon prior to his acute headaches. An individual food test with chicken was followed by a chill, somnolence, pulling and drawing sensations in the cords of his neck and finally a severe headache. Not being completely convinced of the chicken reaction, he tried it on his own initiative after it had been cut out of his diet for a period of three weeks. One-half hour following he complained of stuffiness of his nose, at one hour developed marked tightness and aching of the sternocleidomastoid muscle followed by a severe right-sided headache. He claimed that his headache radiated down the cords of his neck to the right shoulder and that the pains in both his neck and head were accentuated by forward movement of his right arm. Pains at the base of the posterior triangle of the neck persisted for two days. After this food had been avoided for another six weeks he submitted to a third feeding test with chicken; it again was followed by a chill at ten minutes, nasal stuffiness at twenty minutes, somnolence at forty minutes with severe aching cramps beginning in his hamstring muscles at the end of an hour.

At the time of his experimentally induced backache and leg pains he was examined by orthopedic and neurological consultants who could find no evidence of abnormalities, although x-rays of the spine revealed sagittal facets instead of frontal plane facets between the fifth lumbar and the first sacral vertebrae and the presence of a minimal scoliosis. In the opinion of the

orthopedist, these changes were thought sometimes to be associated with backache, but similar findings frequently occurred in the absence of such symptoms.

The experimental ingestion of beef after four days of avoidance was followed by excessive gas, soreness across the lower back and a right-sided frontal headache beginning at the end of three hours. Although the headache had disappeared by the following morning, he continued to have a residual backache throughout the second day. On another occasion the ingestion of beef, under correct conditions of testing, was followed by the onset of aching and drawing sensations in the hamstrings and a severe backache.

An individual food test with milk was associated with chilliness, lassitude and a dull headache but without muscle symptoms. A similar test with orange was followed by the onset of a chill between ten and fifteen minutes, drawing and aching sensations in his legs, heartburn and headache at thirty minutes. Tests with wheat, eggs, and potatoes were without associated clinical reactions.

With the avoidance of incriminated foods, namely, chicken, beef, milk and orange, he has had no unexplained backache, headache, leg or neck symptoms except as he inadvertently ate the above foods. For the past three years he has been able to eat beef and orange in spaced feedings without trouble, but he has found it necessary to refrain completely from chicken and milk.

Case 4.—Another patient, E. F., a housewife and secretary, aged forty-two, has been reported elsewhere,²² and only the details bearing on the question of her muscle symptoms will be cited. Suffice it to say in respect to her other symptoms that she had been subject to bronchial asthma since the age of fifteen, perennial allergic rhinitis, occasional episodes of urticaria and a chronic degree of fatigue. In recent years she had developed the typical clinical features of bronchiectasis, and this diagnosis had been confirmed by x-ray and bronchoscopic evidence; in fact, it had been treated by repeated bronchoscopic aspiration.

One of her major complaints was a sense of pulling, drawing and tightness of the posterior neck muscles and the muscles of the right shoulder and upper arm. This was commonly associated with numbness of the tips of her fingers on the right although both arms and legs readily became numb if maintained in a given position for even short periods. She had also noticed progressive puffiness of her eyes and edema of her ankles. Although she had remained under competent medical observation for a number of years there was no obvious cause for her muscle symptoms, edema or diminished tactile sensation.

At the time of her allergic investigation in March, 1947, there were no abnormalities of her physical examination except those findings consistent with bronchial asthma complicated by bronchiectasis and the typical changes in nasal mucous membranes.

There was no evidence of inhalant allergy as determined from the history or as a result of cutaneous and intracutaneous tests with inhalants.

An individual food test with corn was followed by a marked increase in her fatigue and the delayed develop-

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ment of a definite increase in her ankle edema and an unmistakable accentuation of her asthma. A similar test with eggs was associated with chilling, somnolence, increased asthma and delayed aching sensations of various muscles simulating the prodromal features of the gripe. The experimental ingestion of wheat and milk were not associated with symptoms.

At this point she was placed on a basic type of diagnostic diet including wheat and milk but omitting corn, eggs and other foods of high dietary incidence. On the third day of this plan her diarrhea and other gastrointestinal symptoms ceased, and for the first time in several months she had completely normal stools. Her dyspnea improved to the point that she was able to walk up a flight of stairs, a feat that she had not been able to do for the previous three years. Foods were then returned to this diet according to the escalator plan of additions. After the first meal containing beef she developed an attack of "acute indigestion" followed by severe coughing and asthma which persisted all night. The following morning on awakening, she noticed a recurrence of the pain in her right arm and shoulder in association with generalized soreness of the entire right side of her chest. Other eliminated foods were then added without incident.

After having been completely free of her shoulder pain for a week, she noticed a sharp increase in her coughing during the course of broiling a steak; this was followed by a recurrence of her shoulder symptoms. She was then instructed in preparing the identical meal four days later. She started coughing fifteen minutes after inhaling the fumes of cooking beef; this progressed rapidly into severe asthma which persisted all night. The following morning she again complained of severe aching, soreness and lameness of her right arm and shoulder to the point that it was difficult for her to carry on with her housework.

Four days following the second exposure to beef by inhalation she was induced to ingest one quarter ounce of gelatin prepared from beef. Within the first hour she developed distention, tinnitus and headache. A second smaller dose was then ingested which was followed by alternating chilliness and profuse perspiration and finally, by vomiting. Marked puffiness of her ankles was noted four hours later, followed by severe abdominal cramps and multiple diarrhetic stools containing profuse amounts of mucus. Diarrhea was still present on arising the following morning at which time she complained of extreme tautness and aching of her nuchal muscles, and aching, pulling and drawing sensations in the muscles of her right shoulder.

With the avoidance of incriminated foods, namely, beef, corn and eggs, she has remained completely symptom-free except for an increase of her constitutional symptoms immediately preceding and during the first two days of her menstrual periods. On several occasions she had developed headaches and residual muscle symptoms after the inadvertent inhalation of the fumes of cooking beef encountered in other homes. Her beef sensitivity is of such an extreme degree that on several occasions she had responded with typical symptoms of beef sensitivity following the ingestion of pork or lamb cut on a beef-contaminated butcher block. For the past

year she had remained completely free of muscle symptoms except for the above instances associated with beef exposure.

Case 5.—S. H., a native Norwegian man, aged forty-three, had complained of intermittent pulling and drawing of the posterior neck muscles for many years, his neck feeling tight and "knotty" at times for no apparent reason.

His initial acute attack of generalized muscle aching and soreness developed on a January morning in 1943 after he had been thoroughly chilled during the night by the absence of sufficient bed clothing. Extreme fatigue and intermittent chills persisted through the next day. The second night, even though comfortably warm, he was awakened with the sudden onset of an extremely severe pain at the points of insertion on the cranium of the left posterior cervical muscles. By the following morning there were painful, tender, nodular swellings at the base of the skull, he had continual vomiting for several hours and passed large amounts of mucus in the stool.

At this point he gave up his job and moved to Tennessee. While there he continued to have a poor appetite, daily mucus containing stools, fatigue to such a degree that he was only able to walk short distances and generalized muscle symptoms. His back, shoulders and neck were so stiff and sore on awakening in the morning that it was with the greatest difficulty that he was able to dress and lace his shoes. He also complained of the presence of tender sore areas in his scalp, swelling and irritation of his eyes and periods of several days' duration characterized by profuse and continuous perspiration. Shortly after arriving in Tennessee he started having acute attacks of dizziness associated with an overpowering drowsiness coming on within a few minutes after his customary breakfast of corn bread and corn syrup.

With the continuation of these symptoms, he finally returned to Chicago in the spring of 1944 and, to his surprise, immediately began to feel much better. It is of interest that his diet in Chicago did not include corn, as he had never been fond of it and had eaten it only when it had been served in other homes.

For several summers he had little trouble except for ragweed hay fever. In subsequent winters he had relatively mild recurrences of myalgia in association with other constitutional allergic symptoms as described. After his previous experience he was careful to avoid severe chilling. On many different occasions, however, he noticed the sudden onset of acute pain in his left anterior chest, associated with a steady soreness of the pectoral muscles, left shoulder and upper arm accompanied by a relative shortness of breath. He had been seen by numerous physicians in these attacks for fear that he might be having cardiac symptoms. Repeated electrocardiograms were invariably negative. On one occasion he developed acute cramping sensations apparently localized to the upper left abdominal wall which extended upward over the left side of the chest and into the left anterior neck; this attack developed within an hour after eating a large bunch of grapes. These symptoms were followed within half an hour by the gradual

onset of dizziness, anorexia and nausea. Marked soreness and tenderness of the muscles of the left chest persisted for three days. He tried grapes subsequently and they invariably made him sick. On one other occasion the ingestion of grapes was followed within ten minutes by pains in the fleshy muscles of the anterior chest wall of such a severity as to cause him to lapse temporarily into unconsciousness. Although he is fond of wine, it invariably upsets his stomach, causes profuse perspiration, weakness and residual constipation.

For approximately a year prior to his initial visit in the fall of 1947 he had been subject to increasingly troublesome perennial nasal stuffiness. He had also complained of intermittent bouts of abdominal cramps and diarrhea, the onset of which usually awakened him in the middle of the night.

For the two months prior to his initial visit he had complained of being exceedingly tired in the mornings, having aching, pulling and drawing pains in the muscles of his lower back and posterior thighs. He occasionally had a sharp, shooting cramping sensation in the hamstring muscles which was relieved by massage.

Coincident with starting a farm vacation in the middle of August, 1947, and eating an excessive amount of corn on the cob, he developed profuse rhinorrhea and continual dizziness. He attempted to return to work but was unable to do so because of the vertigo, and he consulted a nose and throat specialist who recognized the probable allergic nature of his symptoms.

On allergic investigation he reacted with positive skin tests to house dust and ragweed pollen. Specific therapy failed to relieve his symptoms, and it could not be determined with certainty that he was clinically sensitive to these agents.

He noticed improvement on the third and fourth days of avoiding corn in preparation for an individual food test. Within a few minutes after an experimental feeding of corn meal and corn sugar he complained of his face feeling flushed, generalized pruritus, followed in turn by nausea, intense perspiration, weakness of his knees and dizziness. Similar tests with wheat and milk were not associated with symptoms. Diagnostic measures were then stopped because of the complete relief of symptoms following the avoidance of corn and grapes, having had no further dizziness, diarrhea, backaches or leg symptoms, and being able to breathe through his nose for the first time in several weeks. Three months later he ate a corn fritter in the evening meal. Within three-quarters of an hour he developed a severe chill, followed by profuse, generalized perspiration, scratchy sensations of his eyelids and extreme tiredness and weakness.

With complete avoidance of corn and grapes he had no hay fever during the 1948 pollen season. It is of interest that as a result of serial intradermal titrations^{18,20} performed at the end of each of the past two pollen seasons he was found to be twenty-five times more ragweed sensitive in 1947 than in 1948.

Although we have not been able to reproduce the original muscular symptoms in this patient following the experimental feeding of corn, it is of interest that his food test was done in the summer months. It is

possible that he might have a thermal food allergy to corn of the type described by Rinkel²² in view of the fact that he had increased muscle symptoms in winter months in association with cold exposure when eating corn but none in the past winter with the avoidance of corn. Although he had unmistakable symptoms following the test and inadvertent ingestion of corn, it also is a possibility that repeated exposure might be necessary to bring about the muscular reactions. The relationship of grape sensitivity and muscular symptoms has been demonstrated on repeated occasions; it is also of interest that during the period of active muscular symptoms he was receiving grape in cream of tartar. The absence of all muscular symptoms for the past two years with the complete avoidance of corn and grape makes it highly probable that the muscular symptoms in this case are on the basis of food allergy.

Discussion

The production of chronic disabling symptoms of myalgia, as illustrated in these cases, usually requires the existence of a high degree of sensitivity to a frequently ingested article of the diet. A masked food allergy response, as described by Rinkel,¹⁸ is usually the responsible mechanism.

Multiple food sensitivity is to be expected in the type of case reported as myalgia of this degree of severity occurs most commonly in the far advanced food allergy patient. The relative incidence of specific foods causing this symptom response is the same as for other manifestations of chronic food allergy, the order of probability being specific sensitization to corn, wheat, milk, eggs, potato, et cetera.¹⁷

It is of interest that each of these five patients had been considered as suffering from psychosomatic manifestations and two of them actually diagnosed as "psychosomatic rheumatism." The point of view that muscle symptoms of the type herewith described are the result of "nervousness" has been repeatedly stated in recent years. Although the author cannot deny that such an interpretation may exist in certain cases, it is difficult to conceive of its mechanism and he has not had the experience of being able to demonstrate experimentally the etiologic role of these factors. The fact that such symptoms are associated with the ingestion of specific allergenic foods is subject to experimental demonstration not only in the cases herewith reported but in many additional individuals. No claim is made that the allergic reaction is the only cause of such symptoms, but in the cases studied, other factors, with the possible exception of cold exposure, did not appear to be operating.

There is more to be said in favor of Williams³¹ conception that manifestations of this type may be on the basis of a physical allergy, a view expressed by Seydell²⁶ and many earlier writers. Although cold exposure appeared to be a precipitating factor in causing a recurrence of muscular symptoms in one case, this type of history was not present in the other cases reported and in the majority of other individuals observed with this clinical condition.

The widespread involvement of various muscles and muscle groups is of interest, and there appears to be no accountable reason for the predilection of certain muscles in individual patients.

One might raise the question that these patients had some other disease to account for their muscular symptoms, but there appeared to be no other obvious interpretation of this type. In no instance was there any evidence of arthritis, as judged by x-rays of the adjacent joints. The possibility that involvement of the chest muscles might be on the basis of pleurodynia or Bornholm disease²⁹ cannot be dismissed but is unlikely in view of the absence of any evidence suggesting an epidemiology as commonly reported for this condition and the ability to reproduce recurrences at will and to effect relief as a result of adjusting the food intake in respect to specific allergens.

Of additional interest is the diagnostic confusion arising when muscular symptoms of this type are localized to the pectoral or intercostal muscles of the left anterior chest. Clinicians were well aware of the possibility that two of the cases cited might be having symptoms of cardiac origin, but repeated clinical and electrocardiographic observations were consistently negative in substantiating such a diagnosis. This course of events has been observed in at least six other patients subject to muscle symptoms on an allergic basis and is believed to be a fairly common cause of bizarre chest pain that is so confusing to the cardiologist.

No attempt has been made to study the histology of the involved muscles during or between attacks in these patients. Such observations in an apparently similar type of series have produced variable results.^{1,2,28} Steiner and his associates²⁷ contrasted the polymyositis of rheumatoid arthritis as differing from the minor changes observed in fibrosis and other diseases affecting the muscles. To speculate on the possibilities of perivascular reactions and edema formation as manifestations of the allergic response is outside the scope of this clinical presentation.

Summary

Clinically, myalgia may be a specific allergic response of striated musculature and may involve regional groups of muscles, a single muscle or a particular segment of a given muscle. The response is highly variable from one patient to another and, although a given food commonly produces the same symptom pattern on different occasions, it may produce symptoms localized to different muscles on other occasions. In some instances a generalized muscle soreness and aching may be present on arising in the morning after the ingestion of specific allergenic goods the preceding day. Patients sometimes describe this generalized reaction as aching all over or liken it to the feeling of having been severely pummelled the preceding night.

Of the various localized reactions, involvement of the posterior cervical muscles, particularly the trapezius and sternocleidomastoid muscles, is the most common. This aspect of the clinical problem has been presented elsewhere.^{10,11} The involvement of other muscles appears to occur in the following approximate order: the gastrocnemius, hamstrings, the lower muscles of the back, the muscles about the shoulder girdle, the pectoral muscles, the intercostals and the rectus abdominus.

When the reaction occurs in the shoulder girdle, it is sometimes confused with the diagnosis of bursitis or arthritis; when localized to the left anterior chest, it is immediately confused with a heart attack; when the intercostals are involved, it may suggest a diagnosis of pleurisy, pleurodynia or spinal arthritis.

Complaints of patients with these symptoms vary from nagging sensations of pulling, drawing, tautness and aching of the involved muscles to violent and sharply localized pain and cramping sensations, both with and in the absence of nodular areas of increased firmness and tenderness in the bellies or insertions of the involved muscles. The affected muscles commonly become more rigid during sleep so that chronic symptoms are apt to be accentuated on arising in the morning. This timing is also typical of the complaints of the patient with a chronic food allergy who has a high degree of specific sensitivity.

These common muscular complaints, described variously as myalgias, myositis, muscular rheumatism, fibrositis, indurative headache, "tension headache" and by other descriptive terms have too fre-

quently been regarded as of psychosomatic origin for the want of another adequate explanation.

The relative percentage of such symptoms resulting from specific allergic reactions cannot be estimated at present, but the fact remains that such symptoms have been experimentally induced in known allergic individuals following the deliberate or inadvertent ingestion of allergenic foods, and finally, many patients with such chronic complaints have been relieved following adequate allergic diagnosis and the subsequent specific avoidance of incriminated allergens.

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EXCERPTS FROM REPORT AND RECOMMENDATIONS TO CONGRESS BY THE FEDERAL SECURITY AGENCY—MARCH, 1951

Page 12—Paragraph 2

"While voluntary insurance has achieved considerable coverage, it offers only limited protection, mainly to middle-income groups in the larger urban areas, and cannot effectively meet the needs of the entire population."

Page 16—Paragraph 3

"Social insurance against the costs of medical care is essential if we are to achieve comprehensive social security and if the benefits of modern medicine are to be available to everyone.

"Private health insurance has achieved considerable coverage in recent years, but it cannot effectively meet the needs of all the people.

"Publicly subsidized private insurance would be costly, complicated, and only partially effective. Government health insurance administered on a decentralized basis as part of a national contributory social insurance system offers the most adequate and economical method of guaranteeing that there will be no financial barriers to needed medical care."

Common Geriatric Dermatoses

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AGING is an insidious process which begins at birth and terminates at death. The complex biologic changes caused by aging do not occur at a uniform rate in all persons. One person may present more manifestations of senescence at sixty than another does at seventy or seventy-five years of age. Heredity, acute illness, nutritional and metabolic disturbances, personal habits, and occupational hazards are among the factors that influence the rate of biologic aging of all persons.

Because of advancements in preventative medicine and definite improvement in diagnostic and therapeutic procedures, medical science has increased the longevity of the human race. This progress has caused a gradual increase in the percentage of population over sixty years of age. Therefore, health problems of this group are becoming more common in the practice of most physicians. Perhaps geriatric medicine will become a recognized specialty. Degenerative changes and chronic incurable diseases common to this aged group present special problems of nursing and therapy. Mental deterioration of elderly patients often presents special problems. The rate of recovery of elderly patients is slower than in younger ones; consequently lack of co-operation and impatience of elderly persons augment the difficulties of the physician and other attendants. This is particularly true in the management of recalcitrant and tormenting pruritus and dermatitis, or eczema, in elderly patients.

Cutaneous manifestations are usually among the first and most easily recognized changes caused by aging. The skin becomes dry, less elastic, wrinkled, thin and scaly. Loss of cutaneous and subcutaneous fat is often an early manifestation of aging. Obliteration of youthful features is known to be distressing to women approaching senescence. Graying and loss of hair usually precedes atrophic changes involving the skin. Loosely adherent seborrheic scales and crusts appear on the face and pigmented spots or senile freckles

develop on the face, neck and dorsal surfaces of the hands. These lesions are often precursors to precancerous senile keratoses. With advancing age the color of the skin changes from pink to a yellowish or grayish tint. A certain type of yellowish tinge of senile human skin is most apt to develop in blond persons who have sustained repeated and prolonged exposure to sunshine. The discoloration is a clinical manifestation of a degenerative process which Weidman⁴ has termed senile elastosis.

Pathologic changes of senescent skin consist of atrophy of the epidermis with increased pigment in the basal layer. Because of degeneration and loss of elastic tissue in the corium, the epidermo-dermal junction becomes flattened. Varying degrees of atrophy of collagen tissue and cutaneous appendages occur, resulting in a decrease in thickness of the corium. Blood supply to senile skin is decreased because of sclerosis of vessels which is an inevitable process of aging. Ormsby³ has pointed out that the histologic degenerative changes which occur in senile skin resemble closely changes seen in xeroderma pigmentosa and in roentgen ray and radium dermatitis.

These changes predispose the senile skin to infections and favor the development of gross degenerative lesions. Furthermore, they are factors partly responsible for recalcitrant dermatitis affecting elderly persons. Concomitant metabolic disturbances, nutritional deficiencies, cardiorenal disease, arteriosclerosis and other manifestations common in persons past sixty years of age may influence the rate of recovery from dermatitis in this group.

Many dermatoses occur in both young and elderly persons; however, certain diseases of the skin are more often seen in older patients or in those past middle life. Among the common dermatoses which occur predominantly during senescence or senility are senile angioma, senile sebaceous adenoma, senile verruca (seborrheic keratosis), senile keratoses and basal and squamous cell carcinomata. These lesions are listed in order of their increasing seriousness and importance. Senile pruritus and various types of dermatitis are common in elderly people and often are difficult to manage. Senile skin may be affected by many other less common dermatoses; however, the cutaneous diseases enumerated comprise the majority of dermatologic problems seen in the elderly.

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Senile Sebaceous Adenoma

Senile sebaceous adenoma is a term suggested by Nomland² for a common benign lesion which occurs most often on the forehead and occasionally on the face of persons past middle life. Prior to Nomland's publication this condition seldom was mentioned in American textbooks and dermatologic literature. Previous authors had considered this lesion to be due to hypertrophy of the sebaceous glands. Nomland observed that this condition resulted from a new growth of acini of the sebaceous glands arising from a lanugo hair follicle. Senile sebaceous adenoma occurs most often on the forehead and at times on the face as a small yellow rounded soft smooth and often umbilicated papule. There are no subjective symptoms. There may be one or several lesions, seldom numerous, and often an associated rosacea of moderate severity while the skin of the face is frequently abnormally oily. Because of the educational program for the prevention of cancer there has been an increase in the number of persons who seek advice regarding this cutaneous lesion. It is benign, not precancerous, and may be removed for cosmetic reasons with the electric cautery or carbon dioxide snow refrigeration.

Senile Angioma

Senile angiomas are angioma-like lesions which occur on the trunk. They are small purplish or bright red and composed of tufts of dilated capillaries in the upper portion of the corium. These lesions are common in persons past sixty years of age; however, it is not uncommon for a few to develop in a person in the early fifties. These ectases are benign and need not be removed except for cosmetic reasons. Electric cautery is an excellent method.

Seborrheic Keratosis (Senile Verruca)

These lesions are sometimes called senile warts. They are common and often numerous. The areas of predilection are the back, shoulders and chest. They frequently occur on the forehead, on the temples, along the hairline of the scalp and on the face, occasionally on the hands, arms and lower extremities. Seborrheic keratoses are more common and numerous in patients past sixty years of age. However, it is not uncommon to see small early lesions on the trunk of individuals near fifty years of age. Early in development seborrheic keratoses are small yellow oily raised lesions with a

fine granular surface. As they enlarge they become brown, and when thickened or large, are often black or dark brown. Their surface becomes more verrucous or uneven and may contain comedones or present small depressions. The involved skin is usually oily and occasionally there is an associated seborrheic dermatitis surrounding a group of keratoses. Seborrheic keratoses seldom become malignant. They enlarge by an upward and peripheral growth rather than by invading the corium. This characteristic presents a "stuck on" appearance, the lesions resembling, in this respect, small areas of mud which have been plastered on a smooth surface.

The diagnosis of seborrheic keratosis usually is not difficult. Occasionally a dark brown or black senile verruca closely simulates a benign melanoma or nevus; however, the surface of the keratosis generally presents small depressions, small comedones, or is granular or verrucous. In case of doubt, the lesions should not be cauterized or traumatized, but should be removed by wide excision.

Occasionally, a seborrheic keratosis may be pruritic. However, this lesion is usually symptomless and need not be removed except for cosmetic reasons, in which case electric cauterization is advised. If the cautery point is not too hot, scarring can be prevented.

Senile Keratosis

In contrast to seborrheic keratosis, senile keratosis is a precancerous lesion and occurs most often on exposed surfaces of the body. The face, nose, ears and dorsal surfaces of the hands are areas of predilection. Blondes are most susceptible and exposure to sun and wind are predisposing factors. Senile keratoses are more common in men than in women. They vary in size, are slightly elevated, and pink or light brown in color. The surface is covered by adherent scales or a thin, dry, adherent light brown crust. Surface beneath the crust is usually uneven and may bleed after the crust has been removed. Senile keratosis may remain unchanged for years or enlarge slowly and become transformed into a basal or squamous cell carcinoma. This transformation is accompanied by a mild inflammatory reaction around the lesion as well as an increase in thickness or infiltration of the base of the keratosis.

Since senile keratosis is a precancerous lesion, it should be destroyed. If clinical characteristics

suggest early malignant degeneration, a biopsy specimen should be taken before treatment is instituted. If malignant degeneration has occurred, roentgen ray, radium therapy or surgical removal are procedures of choice. Benign senile keratoses can be removed satisfactorily by electric desiccation or cauterization. It is important that the lesion be destroyed completely.

Cancer of the Skin

Cancer of the skin occurs commonly in individuals past sixty years of age, but may occur much earlier in life. It may develop from normal appearing epidermis, but usually it arises in a senile keratosis. Leukoplakia of the lip and vulva, arsenical keratoses and keratoses of roentgen ray or radium dermatitis, are other so-called common precancerous lesions.

Cutaneous cancer may be divided into three types: (1) basal cell carcinoma, which is often called epithelioma, skin cancer or rodent ulcer; (2) squamous cell carcinoma, and (3) basal squamous cell carcinoma, a mixed type in which both types of malignant changes occur.

Epithelioma is the most common variety. As in senile keratosis, epithelioma occurs most often on the forehead, nose, face, neck, ears and dorsal surfaces of the hands. Epithelioma appears frequently on the nose, near the inner canthus of the eye and near the margins of the eyelids. If neglected, it may result in irreparable damage, with unsightly deformity. Basal cell carcinoma may be a small papule or a large destructive ulcerated lesion.

A common type of epithelioma is a firm, pearly papule or nodule which frequently has telangiectases on its surface. As the lesions enlarge ulceration and crusting often occur. Such lesions are known as rodent ulcers. The ulcer varies in depth, the base is nodular and the margins are rolled and pearly. Epithelioma enlarges by invasion of adjacent tissues and does not metastasize. Morphea-like epithelioma and superficial erythematous epithelioma are less common and differ in their clinical characteristics from the more common type of epithelioma.

Morphea-like epithelioma is a non-scaly superficial yellowish or ivory plaque which roughly resembles a small area of circumscribed scleroderma. It may or may not ulcerate and, as it enlarges by peripheral extension, there may be central involution with scarring. The margins are often poorly demarcated, making it difficult to determine by

inspection the exact size of the lesion. Portions of the lesion may consist of small pearly papules. Areas of predilection are the forehead, face and neck.

Superficial erythematous epithelioma usually occurs on the trunk. There may be one or more lesions. Psoriasis and arsenical keratoses are frequent concomitant dermatoses. The lesions are round or serpiginous, superficial, small to large coin-sized, pink or light red, well-demarcated plaques. As the plaque enlarges by peripheral extension, the central portion undergoes partial healing with resultant atrophic scarring. All or portions of the margin consist of a threadlike raised pearly ridge. The scarred portion may be scaly, or have small superficial crusted ulcers. Telangiectases are frequently present on the surface of the lesion. Since this type of epithelioma is apt to occur in psoriatic patients, a cursory examination may result in an erroneous diagnosis of psoriasis.

Squamous cell carcinoma is less common than epithelioma, but more malignant. It grows more rapidly and it metastasizes. The degree of malignancy is not uniform for all squamous cell carcinomas. As in the case of epithelioma this neoplasm usually arises secondarily to a precancerous lesion such as leukoplakia, senile keratosis, or radiation keratosis. Most cancers of lips, vulva, and oral mucous membrane are squamous cell type. It may develop *de novo*.

Squamous cell carcinoma may be a papillomatous, nodular, cauliflower-like, fungoid or nodular ulcerative lesion which tends to bleed easily. The base of an ulcerated lesion is thickened because of invasion by malignant cells into adjacent tissues. Margins of the ulcer are rolled, firm, and pink to light red in color. Squamous cell carcinoma is often surrounded by an area of low-grade inflammation.

Basal squamous carcinoma has the clinical characteristics of epithelioma and squamous cell carcinoma. Portions of the lesion consist of pearly papules or nodules while other portions with squamous cell carcinoma have a deeper and more firm infiltration of the skin and subcutaneous tissues. When a suspected basal cell epithelioma metastasizes, it is almost always a basal squamous cell lesion.

It should be emphasized that although the clinical characteristics of cutaneous cancer are well established, a correct classification can be made only by microscopic examination. The prognosis,

as well as the choice of therapeutic procedure, are partially determined by the histopathologic changes. Therefore a biopsy specimen should be taken before a lesion suspected of being cancerous is destroyed, and tissue sections should be made if the lesion is excised.

Treatment of cutaneous cancer is individualized. The method of choice is determined largely by the cellular type, degree of malignancy, the site and size of the lesion, as well as the presence or absence of metastases and degree of invasion and destruction of adjacent structures. Most basal cell carcinomas respond well to roentgen rays or to radium; however, in selected cases excision with plastic repair is indicated. Radiation may be used in selected cases of squamous cell carcinoma, but in most instances surgical excision or destruction of the lesion by chemosurgery is the method of choice.

Senile Pruritus

Pruritus is a common and often annoying complaint of elderly persons. Itching is a symptom and little is known of the mechanism of its production. It is a common manifestation of certain metabolic disturbances, endocrine dysfunction, liver disease, blood dyscrasia and parasitic infestations. Those conditions occur frequently in persons past sixty years of age, therefore diabetes mellitus, azotemia, subclinical icterus, leukemia, Hodgkin's disease, other constitutional diseases and parasitic infestations must be considered as possible causes of pruritus in elderly persons. Frequent bathing and irritation caused by woolen garments worn next to the skin are also important etiologic factors. The term senile pruritus should be restricted to designate essential pruritus affecting senile skin. It is seen more often in men, may be generalized, but more often involves localized areas, with predilection for the extremities. Small blood-crusted excoriations are often the only visible cutaneous manifestations. Itching is likely to be intractable to treatment, more intense in cold weather, and exaggerated by bathing.

Treatment of idiopathic senile pruritus is often extremely difficult. Frequent bathing is contraindicated. A bland soap and tepid water should be used. Soothing applications are indicated—preparations which protect and decrease the dryness of senile skin. A lotion consisting of equal parts of glycerine, ethyl alcohol and peppermint water is an excellent remedy. A more oily preparation, consisting of oil of theobroma 10 per cent in unguen-

tum aqua ros, or a lanolin cream is helpful and pleasant to use. Valuable antipruritics which may be added to these creams are 0.5 per cent phenol and/or 0.12 per cent menthol. Boric acid ointment usually is well tolerated and often of value in the treatment of senile pruritus. Mild sedation for short periods may be required. Antihistaminic drugs are of doubtful value. Multiple vitamins should be administered, as avitaminosis of varying degree is often present in elderly persons. The value of endocrine therapy for senile pruritus has not been determined; however, reports indicate that parenteral administration of 25 mg. of testosterone propionate for men and 1 mg. of estradiol benzoate or other estrogens twice a week are of value in some cases of senile pruritus. This recommendation is in accord with my experience, and I feel that in the management of intractable senile pruritus, a trial administration of these agents indicated.

Dermatitis

The eczema-dermatitis group of skin diseases, which are common to all age groups, comprises the most ordinary complex and distressing dermatoses affecting elderly persons. Because of degenerative changes, dermatitis involving senile skin heals slowly and is often intractable to treatment. Furthermore, severe pruritus disturbs the sleep and prevents rest, thereby impairing the health of a person whose recuperative ability at best is low.

Dermatitis may be caused by multitudinous factors. The mechanism of its production is complex and often obscure. There is also great variance in the clinical manifestations of the common types of dermatitis. The so-called eczema group includes contact dermatitis, disseminated neurodermatitis and seborrheic dermatitis, all of which occur in patients past sixty years of age. Of these, seborrheic dermatitis is seen more often in this age group.

Contact dermatitis may be the eczematous type resulting from acquired specific epidermal sensitivity or may be the consequence of damage due to primary irritants. The hands, arms, face, neck and upper portion of the trunk are areas most often involved. The eruption is usually poorly demarcated, and edema, erythema and vesiculation are often prominent characteristics. Contact dermatitis may involve the covered portions of the body and is frequently caused by dye or other chemicals in garments. The discovery of the cause of contact

dermatitis is often difficult and sometimes impossible. However, a complete and accurate history often provides significant information and, in addition, proper use and interpretation of patch tests often determine the cause of contact dermatitis.

It is doubtful whether atopic dermatitis, of the type commonly seen in young adults, develops for the first time in a person past sixty years of age. However, chronic, dry, thickened, slightly scaly, intensely pruritic dermatitis involving the face, neck, flexoral areas of the extremities and, to a lesser degree, the trunk is not uncommon in this age group. The cause of this type of dermatitis often remains undetermined. In some cases neuro-psychogenic factors seem to be of etiologic importance. In some instances lichenification is secondary to a chronic contact dermatitis aggravated by injudicious use of topical remedies. It is also important to consider the possibility of constitutional disease, and ingested drugs as possible etiologic factors.

Seborrheic dermatitis occurs frequently in elderly persons. Its cause is unknown. It is characterized by a superficial, yellowish-pink, scaly dermatitis which usually starts on the scalp as an excessive dandruff. Areas of subacute dermatitis develop on the scalp and along the hairline, on the forehead, in the eyebrows and on the midportion of the face. Seborrheic scaling of the margins of the eyelids is common. The postauricular folds, external auditory canals, and midportions of the trunk are frequently involved. Scales are small, yellowish to gray, oily and loosely adherent. Pruritus may or may not be troublesome. However, in elderly persons, the itching of seborrheic dermatitis is often severe. Seborrheic dermatitis in these patients commonly involves large areas of the trunk and is prone to occur in the axillary and genitocrural regions, beneath pendulous breasts and in folds of the abdomen. It is common for secondary eczematization, due to impetiginous infection, to occur in those areas. Signs of avitaminosis are not unusual. In uncomplicated seborrheic dermatitis, sulfur ointments are of special value. The scalp should be kept free of dandruff. Sulfur precipitate 5 to 8 per cent, salicylic acid 5 per cent, in a water soluble base is an excellent preparation for the scalp. While under treatment, the scalp should be washed twice a week. For the non-hairy areas the same ingredients in petrolatum are usually helpful. Resorcinol 3 per cent may be added. It should not be applied to scalp of

elderly patients as it discolors gray hair. Secondary impetiginous infections should be treated with penicillin or other antibiotic ointments before the use of sulfur ointment is instituted. Vioform, 3 to 4 per cent in petrolatum, is also a valuable remedy in seborrheic dermatitis and impetiginized dermatitis.

Infectious eczematoid dermatitis caused by pyogenic organisms occurs as well demarcated, round or polycyclic erythematous scaly vesicular, pustular and weeping plaques, and is another type of dermatitis commonly seen in elderly persons. This type of dermatitis often develops following trauma of a pyogenic infection. It may resemble rounded areas of eczematoid dermatitis which develop chiefly on the legs of elderly patients with azotemia, diabetes mellitus and avitaminosis.

One of the most common types of localized dermatitis seen in elderly persons occurs on the legs and is caused usually by stasis of the venous circulation resulting from thrombophlebitis or varicosity of the veins. Ulceration caused by trauma and secondary pyogenic infection is a common complication of stasis dermatitis.

Guy, Jacobs and Guy¹ have shown recently that hypoproteinemia may be an important factor in the cause of dermatitis of the legs in patients past middle age. Edema of the legs and associated dermatitis disappeared following increased protein intake, administration of protein hydrolysates, vitamins, hydrochloric acid, correction of hypochromic anemia and appropriate topical remedies. The nutritional status of an elderly person may be an etiologic factor or alter the course of other types of geriatric dermatitis.

Occasionally stasis dermatitis, with or without ulceration, becomes complicated by sudden development of a disseminated papular, vesicular and eczematoid dermatitis. The mechanism of production of this type of secondary eruption is not well understood. Some authors call this phenomenon autosensitization. The disseminated eruption is considered to be a manifestation of hypersensitivity to some substance absorbed from the exudate of the ulcer or eczematoid dermatitis on the leg. This complication usually occurs following application of some topical remedy to the leg. Perhaps absorption of a protein conjugate of the remedy is responsible for dissemination of the dermatitis. This phenomenon is not uncommon and may be a troublesome complication of chronic stasis dermatitis.

Exfoliative Dermatitis

Exfoliative dermatitis or generalized erythroderma is a serious eruption which is seen occasionally in an elderly person. All or a major portion of the cutaneous surface may be involved. The intensity of erythema, edema and infiltration of the skin varies with the severity of dermatitis. Desquamation may be slight or profuse. Partial loss of hair is common, and at times the nails are shed. Superficial lymph glands are usually palpable. Chilling caused by excessive loss of body heat and itching are often distressing symptoms.

Exfoliative dermatitis may be of the primary or secondary type. The primary type is rare. The secondary type is more common and frequently develops as a complication of some other dermatosis such as contact dermatitis, psoriasis or drug eruption. During the arsphenamine era arsenic was a common cause of generalized erythroderma. It may be a manifestation of Hodgkin's disease, leukemia or other types of lymphoblastoma. Therefore, the possibility of lymphoblastoma must be considered in all cases of generalized erythroderma.

The prognosis of exfoliative dermatitis in an elderly person is apt to be poor; favorable response to treatment is slow. It is not uncommon for the eruption to last for months. Diseases of the lymphoblastoma group terminate fatally, and with other types the patient sometimes dies of complicating pneumonia or uremia.

Treatment is symptomatic and individualized. Bed rest, proper nursing, and correction of nutritional or deficiency disturbances common to elderly patients are important measures. Topical remedies should consist of bland ointments. Petrolatum or boric acid, 5 per cent in vaseline, is well tolerated. Phenol 0.25 to 0.5 per cent may be added if pruritus is troublesome. A stimulating tar ointment may be used if the dermatitis is chronic. However, tar ointments must be used with caution and are not to be prescribed in the early acute stage of the disease. Evaporating lotions are contraindicated. Soap and water baths are to be avoided. Frequent bathing may be harmful; however, addition of corn starch paste to a tepid bath is often soothing. The skin should be anointed soon after bathing. Cases due to arsenic respond favorably to BAL (2,3 dimercaptopropanol). Roentgen ray therapy and other therapeutic procedures used in blood dyscrasias are indicated in the lymphoblastoma group.

Among other common dermatoses which effect

elderly persons are localized neurodermatitis, psoriasis, rosacea, lichen planus, fungus infections and parasitic infestations. Since these cutaneous diseases are not peculiar to this age group, they are not discussed.

Summary

The steady increase in the longevity of the human race has, of necessity, stimulated the interest of the medical profession in geriatric medicine. Cutaneous diseases constitute many of the common and distressing ills of persons over sixty years of age. Certain dermatoses are peculiar to this age group and are manifestations of degenerative changes of senescence, while the clinical course of other skin diseases affecting elderly persons is altered by senile changes in the skin. Furthermore, concomitant metabolic diseases, nutritional disturbance, avitaminosis and/or other systemic conditions influence the clinical course and response to therapy of common types of dermatitis affecting senile skin.

Cutaneous carcinoma, seborrheic keratosis and senile sebaceous adenoma, keratosis and angioma are the most common degenerative cutaneous lesions which occur in elderly persons. Of these, carcinoma and senile keratosis are most serious and important. They should be removed, excised, or destroyed by roentgen rays, radium, desiccation, or by electric cautery. Choice of therapy is not uniform in all cases. The other lesions are removed for cosmetic purposes. They usually can be removed with little or no scarring with electric cautery.

Management of senile pruritus and common types of dermatitis affecting elderly patients often taxes the ingenuity of the physician. Dermatitis heals more slowly in elderly people and often topical remedies are not well tolerated. Over-treatment and injudicious use of irritating remedies are common errors. The choice of topical remedies, as in all age groups, depends upon the severity and acuteness of the inflammatory reaction. Moist compresses and evaporating lotions are indicated in acute edematous vesicular dermatitis, while bland ointments are most useful in sub-acute dermatitis. Tar ointments are especially valuable in dry chronic dermatitis.

Roentgen ray therapy is helpful but must be used with caution and only in selected cases.

Due consideration of concomitant systemic and

(Continued on Page 519)

Kala-azar

Report of a Case and Brief Review of Recent Literature

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IN MAY, 1947, Ecker and Lubitz reported that up to that time only nine cases of kala-azar (black fever, Daukalin, dumtum fever, or Leishman-Donovan's disease) had been diagnosed in the United States. In 1948 Wilner and Haedicke reported a case in which several relapses took place before the final cure was effected. Duffy and Davidson in 1949 added three more cases to the total number reported in the United States. Prior to 1933 only four cases of the disease were reported in the United States. This case is therefore, so far as can be determined, the fourteenth reported in the United States and the first ever reported in Michigan. Strangely enough, the subject of the report was never in the Armed Services as were the subjects of previous reports rendered in the literature from 1942 on.

Since during World War II, many of our servicemen were stationed in areas where this disease is endemic, we should be on the lookout for this condition in such former military patients who have served in endemic areas whenever they exhibit prolonged fever with splenomegaly and hepatomegaly, leukopenia, and anemia—conditions with similar findings being eliminated from the picture. Furthermore, with the increase of air travel, the disease might become more common in the United States than it is at the present time.

Kala-azar is defined in the textbooks as an infectious disease which has as its characteristics progressive splenomegaly and sooner or later a hepatomegaly, long-continued fever, profound leukopenia, and marked anemia with continuous loss of weight and strength and a downhill course until the patient succumbs usually, with intercurrent infection, in two to three years. The disease is caused by a protozoa body which can be found in the cells of the reticulo-endothelial system. It is endemic in Eastern India, Bengal, Bihar, Assam, and Madras, North China, the Mediterranean

Countries, and the African Sudan (a particularly virulent type is reported as coming from this locality), West Africa, Iraq, South Russia, and Turkestan.

It is commonly believed that the vector of transmission is the sand fly (*Phlebotomus argentipes*).

The pathological picture is one of invasion of the reticulo-endothelial system by the Leishman-Donovan body. The parasite engorges the cells of the system until they burst, flooding the blood stream with the organism. The disease causes such a multiplication of the cells of the reticulo-endothelial system and also of the Kupfer cells of the liver that these organs enlarge rapidly to huge proportions. Later, in the course of the disease, the kidney and practically all organs of the body are affected.

The incubation period of the disease is not known, but it is commonly held to be from six weeks to four months, though an incubation period as short as ten days has been reported. It is insidious in its onset, which usually is with a fever, high and continuous or remittent, and accompanied by chills. One characteristic of the fever is that if the temperature is taken at frequent intervals, it will be seen that the temperature spikes twice daily, leading to the Indian appellation "Daukalin" or double-rising fever. After the fever has been present for a short time, the spleen enlarges and can be palpated. Periods of remission and exacerbation occur.

Accompanying these symptoms is a progressive loss of weight, strength, and appetite and in about 50 per cent of the cases epistaxis and bleeding from the gums. Hematologically the picture is one of anemia, leukopenia (1,000 or less) and thrombocytopenia. Blood chemistry studies reveal reversal of the serum albumin-globulin ratio without change in serum protein level. The diagnosis is made definitely only by demonstration of the Leishman-Donovan body in smears from the blood, liver, spleen, lymph glands, bone marrow; or by culturing it from the blood. There are, however, several presumptive tests such as the formol-gel and antimony tests. In the differential-diagnosis of the disease, it is necessary to consider all diseases characterized by fever, splenomegaly, hepatomegaly, leukopenia, and anemia. Among these are malaria, infectious endocarditis, schistosomiasis, lues, typhoid, rickettsias, and infectious mononucleosis.

Treatment is specific with pentavalent antimony, Enostam or Neostibosan, daily by intravenous in-

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jection until three grams have been given, which course of treatment usually requires about eleven days and generally suffices to cure the disease.

Case Report

The subject of this report is J. S., an eighteen-year-old white boy, the son of missionary parents. He was born in India and, except for one visit to the United States, spent his entire life there. Most of his time in India was spent at school in eastern Punjab in the Himalayan foothills. His only visits to the plains of Bengal were during school vacations and these always in the cool seasons. His past history was negative except for two attacks of malaria.

He left the Punjab about the middle of March, 1950, en route to Calcutta to board ship to come to the United States for the purpose of attending college. Between March 15 and April 5, when he arrived in Calcutta, he visited with friends at Jamshedpur, Bihar, and in Bengal. These are areas where kala-azar is endemic. Prior to leaving Calcutta, on April 9, he was given a complete physical examination by the port health doctor. He traveled on a slow ship and the voyage was leisurely by way of the Straits Settlements, Hong Kong, Yokohama, and Manila, and he arrived in San Francisco on May 23. He remained in San Francisco two days and resumed his trip by bus to Chicago, arriving May 28. He stayed one week in Chicago and then traveled again by bus to Grand Rapids, Michigan, to visit his grandfather and aunts (June 4).

One week later, June 11, he noticed that his appetite, hitherto excellent, was failing, and he began to have severe headache, chills, and fever. At one time his aunt took his temperature and it was 105° Fahrenheit orally. A chiropractor living next door gave it as his opinion that the boy had malaria and treated him by manipulation for one week.

He then became concerned and told the family he would call in a physician. He called in an osteopath who diagnosed the condition as malaria and removed the boy to the Grand Rapids Osteopathic Hospital.

He remained in the Osteopathic Hospital about three and one-half weeks. Numerous tests were made, and he was given courses of treatment with atabrine, quinine, penicillin, sulphonamides, chloromycetin, and finally Aureomycin. At this time he apparently had a remission (which is characteristic of the disease), and he was discharged home (apparently with no diagnosis) as cured. After returning home, he remained in bed for one week. However, he did not feel well and had chilly sensations despite the warm weather prevalent in Grand Rapids during the month of July. One week after getting out of bed, he came to this community to visit relatives residing here.

Two weeks after his arrival in this community he became ill, having intermittent, dull, throbbing, occipital headache, persistent fever, nonproductive cough; and no matter what measures he took to do so, he could not keep warm.

The patient was first seen August 2, 1950. A physical examination at that time revealed a temperature of

104°, pulse rate of 96, and respiration of 20. His spleen was enlarged 4 centimeters below the costal margin. The liver was not palpable. A smear made for malaria at this time was negative, however, on the basis of the previous malarial history and physical findings, diagnosis of malaria was made and Guanitol (Lilly) was prescribed, this drug having been previously used with good results in malaria. The patient was not seen again until one week later. At this time the physical findings were essentially the same and there was a slight increase in splenomegaly. The temperature was 106°, the pulse rate 104, and respiration 22 per minute. A blood smear made on admission was reported as positive for malarial parasites and the initial urinalysis showed albuminuria. Blood count (red cells) was 3,500,000, hemoglobin 71 per cent. The white blood count fluctuated throughout his stay in the hospital, reaching its lowest at 1,550 and its highest at 4,100. Daily blood counts were made; the lowest was 3,062,000 and the highest 3,590,000, and hemoglobin ranged from 68 to 71 per cent. A chest plate made on admission because of persistent cough was negative as were sputum samples. The patient was put on a regime of quinine grains 10 three times daily. On the second day following admission to the hospital, his temperature began to show a steady decline until the sixth day following admission to the hospital when it reached 98.4° during the early morning hours, only to rise that afternoon to 101°. From this time on the patient's temperature never again dropped below a basal level of 101.2° until specific therapy was instituted. Blood cultures were made, all of which failed to show any growth. The Widal test for typhoid and paratyphoid was positive in a titer of 1 to 320 and 1 to 40, respectively. However, this could not be considered significant because the patient had received immunization against typhoid fever practically every year since birth, and blood cultures for typhoid were negative. An agglutination test for undulant fever was likewise negative. A sample of blood was sent to the rickettsial laboratory of the United States Public Health Service at Hamilton, Montana, and all reports of tests for Rocky Mountain spotted fever, tularemia, undulant fever, epidemic and endemic typhus, and rickettsialpox were negative. The laboratory at Hamilton reported a low complement fixation against typhus but here again previous repeated immunization played a role. Repeated examination of stools for parasites and *Entamoeba histolytica* were negative. Tests for *Schistosoma* in the stools and urine were likewise negative. Electrocardiograph tests and sinus x-rays were normal. The serum albumin-globulin ratio was not reversed, and the blood calcium level was 9.45 grams. Repeated physical examinations of the patient were negative except for a progressive enlargement of the spleen, and his only complaints were persistent cough, lack of desire to eat, and headache. However, he was usually cheerful, and there was a noticeable brightness of the eyes, which seemed literally to glisten; marked emaciation, the shining skin, and somewhat protuberant tympanitic abdomen were noted. Repeatedly, auscultation of the abdomen revealed normal persistalsis. There was no constipation or diarrhea.

Since practically all diseases with the symptoms of

splenomegaly, fever, et cetera, had been eliminated, the possibility of kala-azar came to mind, and presumptive tests such as the formol-gel and antimony tests were done and found negative. The serum albumin-globulin ratio was again found normal and blood calcium was likewise within normal range. An attempt to culture Leishman-Donovan bodies from the blood was negative.

The temperature was now ordered taken every three hours, and it was noted that each day the temperature would arise from a basal level of 101° to 103° or 104° at least twice. As mentioned before, this is also characteristic of kala-azar and a feature of the disease. A bone marrow sample was then taken, but the parasite was not found. Permission for splenic puncture was sought (the dangers of such a procedure being explained to the parents), and while it was not directly refused, neither was it forthcoming. It must be remembered that this boy is the only son of middle-aged parents. Since all tenable diagnostic leads had been followed and found barren of results and since the evidence at hand (emaciation fever, splenomegaly, persistent cough, anemia, and leukopenia) was strongly in favor of kala-azar, despite the negativity of the tests and despite the fact that parasites had not been found, it was felt that a therapeutic test using the specific drug would be justified as a means of settling the question. Therefore, on August 24, 1950, he was given the first dose of Neostibosan intravenously, and this was repeated daily for eleven days until September 3, 1950.

At the time of the first dose of Neostibosan the temperature was 104° Fahrenheit orally, the pulse was 94, and the respirations were 20 per minute; and from this time on, the temperature began to drop steadily until between the sixth and seventh day of therapy it reached 97° following which it never again rose above normal, in fact, the greater part of the time being at subnormal levels. The pulse rate, which had been at its peak at 120 per minute, varying between this figure and 70, came down to 76 per minute. The respiratory rate dropped down to 18 per minute. The spleen also rapidly decreased in size from 9 centimeters until it became almost completely impalpable. The patient's appetite became ravenous, and he began to demand food between meals. His weight increased, and on September 5, 1950, twenty-six days after admission, he was discharged from the hospital afebrile, feeling better than he had felt in months.

The next opportunity to see the patient presented itself two weeks after dismissal from the hospital. He was at that time, and had been, afebrile. The spleen was no longer palpable, and he was eating like an eighteen-year-old should and had gained 12 pounds in weight. The case has since been followed by correspondence. He entered college and has remained in good health, being checked at intervals by the college health service.

Conclusion

The incubation time of the disease in this case has been about two and one-half months, assuming that the first exposure took place in March during the visits in Bihar and Bengal.

MAY, 1951

1. It would seem that the positivity of the presumptive test depends on the reversal of serum albumin-globulin ratio, and such a reversal was not found in this case.

2. The same may be said of the absence of hepatomegaly. It may be a late feature of the disease.

3. In the absence of a positive blood culture or bone marrow smear or because of withheld permission for splenic puncture, because of the dangers involved, the diagnosis of kala-azar by a therapeutic test may be a rational procedure for diagnosis as it is in malaria.

4. The red blood cell count was never found to be lower than 3,260,000, which is in marked contrast to the low red counts reported in other cases. The red cell count found in other reports might also indicate that the other cases were further advanced in their course than this one, and that the profound anemia reported in other instances might likewise be a late feature of the disease.

5. The fever dropping after quinine may be indicative of co-existence of the two diseases (malaria and kala-azar).

Summary

A case of kala-azar, the fourteenth of its kind in the United States and the first, so far as can be determined, in non-former military personnel since the beginning of World War II, is reported. It is felt that splenic puncture may sometimes be dangerous and other methods of diagnosing not satisfactory in disclosing the presence of parasites, and therefore, treatment with the specific drug is a valid and valuable way of making the diagnosis. Kala-azar should always be considered as a possibility in any person coming from areas where it is endemic, exhibiting persistent fever, persistent cough, splenomegaly, anemia, and leukopenia as well as progressive emaciation, with or without skin pigmentation. The protuberant abdomen, the shining skin and the bright, glistening eyes, once seen, will always remain in the memory of the observer.

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A Review of Endometriosis

Summary of Thirty-two Cases at Hurley Hospital

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ENDOMETRIOSIS is a disease entity which has rightfully received much thought and study during the past few decades, and it is the purpose of this paper to present some results of the various investigations, theories, and clinical data now prevalent in the medical literature. Endometriosis is not strictly an inflammatory condition, nor is it a true neoplastic tumor. However, it is a disease demonstrating tissue having the appearance of endometrium outside the proper site for such endometrium, i.e., in a location different from the mucosal lining of the uterine cavity. Despite the apparent benignity of this disease, it is capable of widespread involvement^{70,71} and is becoming a much more frequent diagnosis at pelvic laparotomy.¹⁵

"The etiology of endometriosis cannot be satisfactorily explained by any one theory . . ." ⁶⁵ Fr. Von Recklinghausen ^{9,36,42} advanced a theory in 1895-1896 of activation of Wolffian body remnants. Cullen^{9,36} followed in 1896 with his Mullerian duct hypothesis. In sequence, Kossman⁹ in 1897, Ivanoff^{9,36,42} in 1898, Sampson^{9,36} in 1921, Halban^{9,36,42} in 1924, and Heim³⁶ in 1933 all set forth various ideas, the best known being Sampson's "menstrual regurgitation" and Heim's "coelosis" theories. Sampson ⁷⁷⁻⁸⁶ stressed that endometriosis was caused by ectopic endometrium, which "at times escapes into the peritoneal cavity from or through the fimbriated end of the tube . . . and lodges where such material would be likely to fall, especially on the lateral surface of the ovary, on its free border, and in the cul-de-sac . . ." ⁷⁹ Heim believes in Iwanoff's serosal-epithelial theory but states that embryonic mesenchyme is the mother tissue. In brief, Ranney⁷⁴ explains the theory on the basis of embryonic celomic cells retaining the potentiality of forming tissue indistinguishable from endometrial tissue.

Whether called endometriosis, adenomyosis, adenosis, Mullerianosis, endosalpingiosis, endometri-

oma, et cetera, and whatever the etiology, this disease is one in which tissue similar to endometrium is found in various locations outside of the normal. "The invasions and disseminations of benign endometrial tissue employ the same channels as the invasions and disseminations of cancer."⁸¹ Bits of this tissue in some way reach the various portions of the pelvis, especially the ovary, and if it is actually uterine mucosa, a reaction to hormonal stimulation will occur. Novak⁶⁸ describes the histological features, stating that microscopically the tissue is endometrial-like, having glands, epithelium and stroma. The latter, however, may be poorly marked or absent, and portions of the wall of the lesion may have lost the endometrial lining. A characteristic feature is the presence of a broad zone rich in large phagocytic cells laden with blood pigments, just beneath the degenerating endometrium or in place of this. These cells are "endothelial leukocytes or pseudoxanthoma cells."⁶⁸ These are large and polyhedral, resembling lutein cells. This, he concludes, is almost diagnostic even in the absence of typical epithelium or gland formation. One may find the same picture as within the uterus, namely, scalloping and tortuosity of glands with a cyclic reaction corresponding to the uterine endometrium. There may be a secretory reaction or a proliferative type which is immature or unripe and not capable of full cyclic response. Often the typical Swiss cheese hyperplasia is found.

There are two types of endometriosis—internal and external. The latter is the type most often discussed, and includes that which occurs outside the uterus in the ovaries, pelvic ligaments, umbilicus, abdominal scars, et cetera. The internal type is often called adenomyosis, and is a benign invasion of endometrium into the uterine musculature. The uterus may be slightly or markedly enlarged, and often has thick walls. Commonly there is an adherence of this organ to the surrounding tissues. In cross section, there is seen a diffuse asymmetrical increase in the size of the wall. There may be dark brown hemorrhagic areas or even small chocolate cysts within the myometrium, which are soft spongy areas of endometrial-like tissue. However, stroma only with no glandular formation may be all that is present. The normal endometrium may not be unusual, but often it is thickened and polypoid. Usually in internal endometriosis the cyclic changes are not as marked as in the external type. Very often the diseased areas show a proliferative type endometrium, while the normal endometrium

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is secretory in type. It seems that this particular ectopic endometrium responds only to the estrogenic hormone.

The misplaced tissue is governed by the same physiological laws in relation to menses, pregnancy, and menopause as the mucosa lining the uterus.⁴⁵ The ovary seems to be the most favorable site for growth in external endometriosis. Here one may see lesions varying in size from a few millimeters to several centimeters in diameter. There may be bluish-black areas on the surface, or larger cystic portions, which, when incised or ruptured, reveal a thick, chocolate-colored substance. It should be remembered, however, that such chocolate-colored cystic fluid is not pathognomic of endometriosis, as a cystadenoma, follicular cyst, or corpus luteum cyst may also show a similar fluid. In the smaller endometrial cysts, adhesions are formed each time the cyst ruptures. At the next cycle, additional pressure is needed for rupture. In time, if the pressure becomes sufficient to destroy the endometrial-like tissue, activity ceases. This serves to explain why the surgeon often finds many adhesions without other demonstrable evidence and with the patient presenting fewer complaints after the disease has been active for some time. Very often, however, a fragment of ectopic endometrium is released when the cyst ruptures, and new implantations occur. Sampson⁷⁷ in his original article states that such cysts are endometrial in origin because the disease as well as the ectopic lesions are active during the menstrual life of the patient, and the epithelial lining of such ovarian hematomas is similar to that of uterine hematomas. Periodic hemorrhages resembling old menstrual blood occur, and the histologic changes in the implants often correspond to the phase of the menstrual cycle of the patient. Other locations for external endometriosis, resulting from new implantations from rupture of an ovarian endometrial cyst, formed from the backflow of endometrium through the tubes, or arising as new growths of celomic epithelium include the serosal surface of the uterus, tubes, the pelvic ligaments (especially the uterosacral ligaments), plevic and abdominal peritoneum, intestines, and omentum. In the extraperitoneal areas one may find endometrosis in the cervix, vagina, rectovaginal septum, vulva, inguinal canal, umbilicus, bladder, abdominal wall scars, lymph nodes, and even in the thigh and arm.

Adenomyosis in this country is more frequent

than endometriosis (external). One series of cases²² gave 49.6 per cent internal endometriosis (adenomyosis), 36.5 per cent external endometriosis, and 13.9 per cent having a combination of both. Yin¹⁰¹ found external endometriosis was three times as frequent as adenomyosis. In our own series, 84.4 per cent was of the external variety, 6.25 per cent internal, and 9.35 per cent both.

It has been said that if a patient who is over twenty-nine years of age complains of an increasing dysmenorrhea plus an increase in her menstrual flow, together with some symptoms of pelvic inflammatory disease and sterility if married, the attending physician should seriously consider endometriosis. Holmes⁴² gives a tabulation of the various symptoms as follows:

Dysmenorrhea, acquired	66.2%
Mennorrhagia, metrorrhagia, polymenorrhea	64.9
Sterility	46.5
Abdominal pain	42.5
Constipation, obstipation	30.0
Sacral back pain.....	28.7
Nervousness	21.2
Pressure in pelvis.....	20.0
Bladder symptoms	15.0
Pain referred to hips, thigh, groin.....	13.7
Rectal pain	7.5
Dyspareunia	7.5

It is important to recognize that the dysmenorrhea is of the acquired variety, and it generally increases as time goes on. The location of the pain, whether in the pelvis, back, rectum, et cetera, does not necessarily indicate the site of the maximum number or size of the lesions. Payne⁷⁰ states that more than half of the patients have abnormal menses. It is interesting to note that in direct or internal endometriosis (adenomyosis) there seems to be more menorrhagia and metrorrhagia and the dysmenorrhea is not constant. This can be explained on the basis that this type of lesion probably does not participate regularly in the menses. Adenomyosis can be suspected in multiparous women over thirty-five years of age with profuse uterine bleeding and no demonstrable pelvic pathology. Fallas and Rosenblum²² reported 260 cases and compared the dysmenorrhea and excessive bleeding, showing the former to be greatest in external endometriosis and the latter greatest in the combined type. There was, however, a distinct difference between excessive bleeding in the external and internal types, being greatest in the latter. In the series of cases reviewed at Hurley Hospital (Flint, Michigan), the average age of the patient was 34.5 years, and tabulation of the various symptoms revealed the following:

ENDOMETRIOSIS—THOMPSON

Thirty-two Cases Reported from July, 1945, to July, 1950

Symptom	Number Patients	Per Cent
Lower abdominal pain.....	15	47.0
Irregular menses	12	37.5
Dysmenorrhea	4	12.5
Pressure in pelvis.....	2	6.3
Backache	2	6.3
Vaginal discharge	2	6.3
Nervousness	1	3.1
Melena	1	3.1

Aside from the various symptoms described above, there are several physical findings which are suggestive of endometriosis. At pelvic examination, a rough, somewhat shotty feeling to palpation in the cul-de-sac may indicate endometrial implants in that area. There may be a moderate fixation of the structures in the pelvis, especially the lower uterine segment. The uterus may be moderately and diffusely enlarged, and often a shallow, thickened and nodular vaginal vault will be found. Quite commonly there is retrodisplacement of the uterus with a distinct lack of mobility. The ovaries are enlarged and adherent, but usually there will be no history of pre-existing infection. There will be found a shortening and increased sensitivity of the uterosacral ligaments. In general, the pain experienced by the patient on pelvic examination is out of proportion to the findings. If the disease has attacked the cervix, vagina, vulva, or umbilicus, small bluish cysts may be seen, which, at the time of the menses, become swollen and tender and may even discharge a few drops of blood. Still other implants, such as in the inguinal region, may also swell at the time of the menstrual period and present a fairly definite tumor mass. At operation, one may find cysts of the ovaries containing a chocolate-colored fluid as well as many adhesions. Small bluish to purplish spots may be visible on the surface of the ovaries, broad ligaments, uterus, or bowel. Blood as well as the chocolate fluid may be found within the abdominal cavity. Because of the adhesions, implants, and the puckering of tissue, scarring occurs in the paracervical tissues and about the rectosigmoid area particularly. Care must be taken in dissection not to enter the bowel or ureters. With the latter, especially, improper mobilization of the uterus, together with the scar tissue, causes the ureters to be displaced upward and often much closer to the cervix than normally found. Commonly coexisting with endometriosis, according to Counsellor,¹³ is leiomyoma of the uterus, which

he found in 54.5 per cent of all cases. Fallas and Rosenblum²² discovered 45 per cent leiomyomata, and Holmes,⁴² 53.7 per cent. A common associated lesion also is endometrial hyperplasia. The clinical findings at surgery in our group of cases were:

Finding	Number Patients	Per Cent
Chocolate cysts of ovaries	10	31.25
Ovarian cysts, simple	10	31.25
Leiomyoma	7	21.90
Endometrial pelvic implants	6	18.75
Pelvic inflammatory disease	3	9.38
Retroversion of uterus	2	6.25
Hydrosalpinx	2	6.25

And one patient each (3.13 per cent) had a finding of endocervicitis, cervicitis, and salpingitis. The microscopic pathology of our various cases revealed the following:

Pathology	Number Patients	Per Cent
Endometriosis of ovaries	22	68.8
Adenomyosis	6	18.75
Salpingitis	9	28.1
Leiomyoma	6	18.7
Endometriosis of broad lig.	5	15.6
Involucional atrophy of uterus	3	9.4
Endometriosis of tube	2	6.3
Oophoritis	2	6.3
Hydrosalpinx	2	6.3

And one patient each (3.13 per cent) had endometriosis of the uterosacral ligaments, endometritis, cystic ovaries, chronic appendicitis, placental tissue, and carcinoma of the uterus. It is interesting to note that we also found thirty-one additional cases of so-called chocolate cysts of the ovaries without microscopic evidence of endometriosis.

With all of the above described signs and symptoms together with a careful history, one should suspect endometriosis. However, in a differential diagnosis the physician must consider a ruptured ovarian hematoma or follicle, uterine myoma, chronic subinvolution, ectopic pregnancy, appendicitis, ovarian carcinoma, ruptured duodenal ulcer, tube-ovarian abscess, carcinoma of the rectosigmoid colon, and pelvic inflammatory disease.

The treatment of endometriosis must of necessity be divided into a medical regimen or surgical removal. According to Meigs,⁶² the medical treatment is not as yet of great importance. Testosterone stops the disease by inhibiting the action of the pituitary gland as far as follicle stimulating and luteinizing hormones are concerned. There is cessation of the ovarian-uterine cycle. He states that this may directly counteract the effect of estrogen

on the proliferating cells of the endometrium also. Hirst⁴⁰ states that testosterone will not cure endometriosis, exerts little if any regressive effects on the implants, and definitely has only a temporary action. Estrogenic hormones in large doses will accomplish the same end result, but caution must be exerted in the menopausal patient for fear of stimulating the implants. Meigs⁶² believes that endometriosis is the result of some abnormal physiology and not a true disease or tumor. According to Beecham,⁶ endocrine therapy deserves much further consideration.

Meigs⁶² also believes that earlier marriages with the production of more babies, especially in the higher intellectual groups, is good treatment in itself. Various investigators^{6,60,62,88,90} have found the percentage of endometriosis in ward patients from 8 to 12 per cent and in private cases from 26 to 35 per cent. Often endometriosis is found in a patient who has had one or two children, and then a period of several years without a pregnancy. Radium or roentgen therapy may be used in the treatment of endometriosis. Dannreuther¹⁸ believes that intra-uterine radium is best for adenomyosis. With x-ray, subcastration doses are usually insufficient to cause relief. However, as mentioned by Sutton,⁹⁵ many clinicians do not like to use x-ray therapy prior to operation because of the possibility of error in diagnosis. An absolute diagnosis is rarely made prior to operation, and patients are usually operated for some other pelvic condition. About 50 per cent of all patients have had previous surgery. In general, the treatment is conservative, whether medical or surgical, under the age of forty and radical over this age. Randall⁷³ says appropriately, "It is not necessary to castrate women indiscriminately because of endometriosis." It is true that cessation of ovarian function will cure the disease, but often, "hysterectomy, like pregnancy, interrupts the menstrual function and this alone seems to be beneficial."⁷³ Resection of portions of one or both ovaries often relieves the patient. Presacral neurectomy in selected patients may help, but usually only in adenomyosis, for this nerve distribution is such that resection would not help those with ovarian or broad ligament pain. In extensive disease or in women past the child-bearing age, radical surgery is indicated. If, however, extensive adhesions are present, it will suffice to perform a subtotal hysterectomy (together with a bilateral salpingoophorectomy) rather than run the risk of severing the ureter near the cervix or

perforating the bowel. The endometrial cells invade the muscular wall of the intestine and peritoneum, and the lesions cannot be separated easily. This accounts for the high incidence of fecal fistulae. One group of investigators²² found the total amount of conservative surgery was twice that of radical procedures. However, 93.1 per cent of cases of endometriosis was not suspected or diagnosed preoperatively. With conservative surgery, 63.6 per cent were relieved entirely and 36.4 per cent relieved to a great extent. With radical surgery, the corresponding figures were 90.9 and 9.1 per cent, respectively. In our series of cases, conservatism with resection of portions of the ovary, removal of one ovary, et cetera, was carried out in 53.1 per cent. Radical surgery with bilateral salpingoophorectomy, hysterectomy, or both was done in 47.0 per cent. In this latter group, all patients but two were over forty years of age. Roentgen therapy was used in one case. It is evident that in the younger age group, medical treatment or conservative surgery is the treatment of choice in hopes that the patient will become pregnant. A subsequent operation will probably be necessary, and although the odds for a pregnancy are long, these patients can and do become pregnant. Radical surgery in older women is employed, for, with the removal of the ovarian stimulus, the endometrial implants will regress and cease to function in a cyclic manner.

Prophylactically, various pathological conditions should be remedied. Cervical strictures or stenoses should be opened, polyps removed, and retroversions corrected. Rough pelvic examinations, especially near the menses, should be avoided. Rubin tests just before or just after a calculated menstrual period or after a dilatation and curettage should be eliminated. The use of vaginal or uterine packings, unless absolutely necessary, and of the Hegar-type dilator should be discontinued. With the uterus upright and in correct position, obstructions will be eliminated and free drainage will result. All of the above, in theory, will help to prevent the backflow of blood through the tubes into the abdominal cavity. According to Dannreuther,¹⁸ if Sampson's theory is correct, the plugging of the vaginal outlet with cotton tampons during the menses should be another causative factor in endometriosis.

An attempt has been made to summarize the current knowledge concerning endometriosis, giving the various theories of etiology, probably patho-

genesis, signs and symptoms, and treatment. Sampson's theory of retrograde menstruation together with the celomic hyperplasia theory of Meyer, Heim, and others seem to be the most probable causes of this disease at present. It seems fairly certain that the implants outside the uterus are affected by a hormonal stimulus and function in a manner similar to that of endometrium. The chief symptoms, according to the literature, are a progressive dysmenorrhea with menstrual irregularities and a relative sterility. In our study, however, lower abdominal pain ranked first and menstrual irregularities second. The majority of reports show the most common site for this disease seems to be within the uterine musculature (internal endometriosis or adenomyosis), while the second most common location is in or on the ovary (external endometriosis). Again, our study differed in that the external type was far more prevalent, the most common site being the ovary. Conservative therapy is indicated in the young women within the child-bearing age, and radical surgery with extirpation of the ovaries and uterus is the best treatment in the older age group.

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Congenital Paralysis of the Inferior Oblique

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CONGENITAL PARALYSIS of the inferior oblique is the rarest of any of the isolated ocular muscle insufficiencies.

A study of eleven such cases (illustrated in detail in an accompanying motion picture) revealed a structural anomaly in nine that has not been previously described in the literature. All eleven cases showed a complete paralysis of one or both inferior obliques, as evidenced by a failure to obtain voluntary elevation up to or above the horizontal plane with the affected eye in the fully adducted position. In nine of the cases, elevation was thus limited even by manual methods as fixation forceps at operation or preoperatively under a local anesthesia. Both the voluntary and manual elevation increased as the eye moved toward the primary position with full elevation when the eye reached the mid-line position.

The restriction to manual elevation proved to be due to a congenitally short anterior sheath of the homolateral superior oblique. In five of the cases that were operated on, the superior oblique was exposed, the sheath dissected free from the tendon and cut transversely. This procedure resulted in free manual elevation in the previously restricted field.

The tendon sheath of the superior oblique normally acts as a check ligament for the inferior oblique. Anatomically it has a fixed attachment to the pulley and periosteum in this region and at the insertion of the superior oblique. As the insertion of the superior oblique is posterior to the center of rotation of the eye ball, the distance between it and the pulley will increase as the eye is adducted or elevated and decrease as the eye is abducted or depressed.

The following clinical characteristics seem to warrant the name of superior oblique tendon sheath syndrome to this type of congenital inferior oblique paralysis:

1. Complete paralysis of the inferior oblique

(Continued on Page 549)

Presented at the eighty-fifth annual session of the Michigan State Medical Society, Detroit, Michigan, September 20, 1950.

Detroit Physiological Society

MEETING OF DECEMBER, 1950

The Use of Small Bowel Segments as Ureters

DON MACLEAN and CHARLES G. JOHNSTON,
Department of Surgery
Wayne University College of Medicine

Published by title only.

The Formation of Prothrombin Derivatives from Purified Prothrombin

WALTER H. SEEGERs, EDNA B. ANDREWS and
ROBERT I. McCLAUGHRY
From the Department of Physiology and
Pharmacology,
Wayne University College of Medicine

Purified prothrombin can be activated slowly by dissolving the protein in a 25 per cent solution of sodium citrate. The activation takes place during a period of about twelve hours. During that time, it is possible to follow the activation with quantitative analytical techniques, including electrophoresis analysis.

The activation of prothrombin can be blocked by adding small amounts of 3, 4, 4'-triaminodiphenyl sulfone to the prothrombin dissolved in 25 per cent sodium citrate solution. This not only blocks the activation of prothrombin but causes it to be transformed into a derivative which is not sensitive to activation by the biological activators calcium plus thromboplastin plus Ac-globulin. This thus represents a derivative of prothrombin not heretofore described. Another derivative can be formed by adding 3-chloro-4, 4'-diaminodiphenyl sulfone to purified prothrombin dissolved in 25 per cent sodium citrate solution. Under such circumstances a derivative which is refractory to the action of calcium plus thromboplastin plus Ac-globulin forms within the first thirty minutes. This derivative transforms into a state which can be activated by calcium plus thromboplastin plus Ac-globulin. It may be an intermediate in the formation of thrombin and it may be that prothrombin always undergoes such alterations before it becomes thrombin.

Observations on the Bone Marrow in Hyperthyroidism and Hypothyroidism

ARNOLD R. AXELROD, M.D., and
LAWRENCE BERMAN, M.D.

From the Departments of Medicine, Pathology and Anatomy, Wayne University College of Medicine and City of Detroit Receiving Hospital.

The relationship between bone marrow activity and thyroid gland function has not been studied adequately. Our investigation of thirty-seven patients with hyperthyroidism and hypothyroidism based on blood and bone marrow studies, includes quantitative analyses of megakaryocytes, fat and cell content of histologic sections of aspirated marrow obtained during life.

The blood changes in hyperthyroidism do not form a constant pattern. However, changes in the peripheral blood observed experimentally and in some patients with hyperthyroidism may be due, in part, to excessive hemolysis. The bone marrow in hyperthyroidism exhibits hyperplasia of all myeloid systems with extension of the marrow organ. The most significant change in the differential pattern of the marrow is relative lymphocytosis which may reach levels considered typical of chronic lymphatic leukemia.

In hypothyroidism the usual blood changes include macrocytic anemia and normal or slightly diminished leukocyte and platelet counts. In the bone marrow there is hypoplasia of all myeloid elements which may or may not be accompanied by a reciprocal increase of fat content. Hypothyroidism should be strongly considered in any patient having hypocellular marrow with macrocytic anemia.

MEETING OF JANUARY, 1951

Relation of Sodium Chloride Depletion to Urine Excretion and Water Intoxication

WILLIAM R. BRISTOL
Wayne University College of Medicine

Published by title only.

**Lymph Drainage of Greater and Lesser Omenta
Including the Stomach**

DAYTON O'DONNELL
Providence Hospital

Published by title only.

Cardiodynamic Effects of Mitral Commissurotomy

E. R. MUNNELL, M.D. (by invitation) and
CONRAD R. LAM, M.D.
Henry Ford Hospital, Detroit

Twelve patients with severe mitral stenosis have been operated on with the purpose of opening the valve by the method of Bailey and his associates (commissurotomy). The operative exposure of the heart and great vessels has given a good opportunity for a study of the pulse patterns of the left auricle and pulmonary artery before and after the incisions into the stenotic valves.

An impedance gauging system developed for recording biologic pressure variables (Hathaway system) was used to obtain the pressure patterns. The gauges were activated by inserting a medium bore needle attached directly to the gauge into the chamber to be studied. Moment to moment changes in pressure were observed during the operations on a monitoring oscilloscope and tracings were made on a photographic recording oscillograph for later consideration.

The typical contour of the pulmonary arterial pressure curve has thus been obtained with greater accuracy than has been possible by catheterization. The left auricular pressure patterns have varied depending on the degree of stenosis and the presence or absence of auricular fibrillation or unsuspected regurgitation. The degree of success attending operative intervention of the mitral valve has been predictable by a study of the post-commissurotomy tracings.

MEETING OF FEBRUARY, 1951

**The Biosynthesis of the Plasma Proteins—
Fact and Fancy**

LEON F. MILLER, Ph.D., M.D.

Department of Radiation Biology, University of
Rochester, School of Medicine and Dentistry,
Rochester, New York

A brief historical survey of the organs of origin of the plasma proteins reveals that virtually every

organ in the mammalian body has been suspected of giving rise to one or more of the plasma proteins. The weight of clinical and experimental evidence, however, has most strongly supported the concept that the liver is the organ most important in the biosynthesis of the plasma proteins.

A direct study of the isolated surviving rat liver *in vitro* yields evidence that the liver synthesizes all plasma albumin and fibrinogen and at least 80 per cent of the plasma globulin fraction. Livers are obtained from adult Wistar strain rats and rapidly incorporated in a simple system for the continuous perfusion of isolated intact organs with heparinized oxygenated blood at known temperature and pressure. With the aid of lysine- ϵ -C¹⁴ the liver is found to respond to variations in amino acid substrate in a fashion qualitatively and quantitatively analogous to that of the intact animal. Very little plasma protein is synthesized when the liver is offered only lysine- ϵ -C¹⁴ in the perfusing blood. The addition of the essential amino acids enhances plasma protein synthesis tenfold. Protein synthesis is further increased by the simultaneous addition of the non-essential amino acids. When under optimal conditions for plasma protein synthesis DL-lysine- ϵ -C¹⁴ is replaced by D-lysine- ϵ -C¹⁴, protein synthesis is less than 10 per cent of that seen with the DL-lysine- ϵ -C¹⁴.

The surviving carcass of normal Wistar strain rats, posterior to the second lumbar vertebra, with or without kidneys, has been found to synthesize plasma globulins from a complete mixture of amino acids containing DL-lysine- ϵ -C¹⁴. Although the amino acids are rapidly removed from the continuously perfused heparinized blood, the total plasma protein synthesized amounts to 5-20 per cent of that synthesized by the liver from the same amino acid mixture in the same time.

Weight for weight, the liver is at least 200 times as active as the carcass in plasma protein synthesis. On a relative basis the skeletal muscle, kidney, and testes have produced far more tissue protein than plasma protein. The liver, on the contrary, synthesizes an amount of plasma protein of the same order of magnitude as that of liver tissue protein.

The results of these direct experiments firmly support the notion that the liver plays a dominant part in the biosynthesis of the plasma proteins, and the technique of isolated organ perfusion coupled with the use of isotopes affords a valuable system for the study of various problems in connection with the biosynthesis of proteins.

Dr. Leon L. Miller was the annual guest speaker of the Society at the February meeting.

Little Errors

One of the major problems of public relations we in medicine must consider and help control is that of chronic ailments. Today there are twenty-eight million people, or one out of every six, who suffer from chronic illnesses. We must devise some simple method of mass screening to detect the early cases and then be prepared to provide treatment for conditions that are both recent and old. Of this group seven million are disabled, and two million are invalids. Eleven million five hundred thousand of our population are over sixty-five, and by 1980 this number should reach twenty-two million. The problems herein presented are tremendous, but are not hopeless. Think of the progress we have made in the treatment of diabetes, syphilis, pernicious anemia, diphtheria, smallpox, malaria, pellagra and rickets, to name but a few. Because chronic disease means so much financially, medically, and socially to the patient and because it affects our national economy, we must bend every effort to direct this phase of our American life under the aegis of Blue Cross and Blue Shield, or some comparable agency which has as much or more to offer.

While we are acting as guardians of our patients' health, we must also promote a reform in education. Our Constitution cannot be ignored. Patriotism must be rejuvenated. Racketeers and felons must lose their political protection and be properly punished. Only then will we gain in individual responsibility and property rights. We must be able to plan our budgets wisely and reduce indebtedness, which will never take place under the bureaucratic direction and spending taking place in Washington now.

In our public relations planning, we must decide whether or not an emergency exists. If so, is it singular or multiple? Is the danger external or internal? What defenses should we use and how can they best be prepared?

We know there is an external danger and every one is constantly aware of it. We have endured two World conflicts in our efforts to maintain freedom and are now engaged in another war. Each conflict finds an increasing acquiescence to Socialist ideologies which eventually leads to communalism by force *which is Communism*. If our bureaucrats can spend us into insolvency, Socialism and Communism are bound to follow. This, then, becomes our internal danger. This type of reasoning can only lead to the conclusion that the external struggle is only a means to promote impending disaster from within. Can the men and women of medicine meet this challenge? If we can convince enough of our patients that they must promote individuals for American leadership who are above dishonesty, greed and intolerance, then we shall have rendered such a service as will live long in the memories of our children. When we win a moral victory at home, we shall be accorded more respect and co-operation from abroad. The areas of despotism will shrink in favor of freedom and government based on the individual's rights. All we need to do is live in unison with our proclaimed principles.

For many years the little errors of apathy have been allowed to accumulate. Today, the obstacles which have pyramided from our neglect will need the best united efforts our public relations program has to offer.

President's



Message

C. C. Humphrey M. D.

President, Michigan State Medical Society

Editorial

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
GRAND RAPIDS—September 26-27-28, 1951

WE SALUTE

DR. LUNETTE I. POWERS, M.D., of Muskegon, Michigan's foremost family physician for the year 1950. It was fitting and proper that a woman should occupy such a place in our esteem at some time, since women are practicing medicine along with the rest of us, and are doing an extremely good job of it. Dr. Powers seemed to satisfy all the requirements—long years of faithful service to her community, acute interest in noncurricular matters, a keen sense of loyalty and responsibility. Dr. Powers seemed a natural choice for the high honor given her, and the Michigan State Medical Society, the Council, and THE JOURNAL are happy to tender our true and sincere good wishes for the future, and commendations for a life well lived.

THE AMERICAN MEDICAL ASSOCIATION for its more than a century of leadership in building the medical profession of our country into a well-knit, progressive, dynamic group who have in the short space within memory of some of us increased the well-being and life expectancy beyond all thoughts or expectation. It has demonstrated the American principle of independent action. On our own initiative, we have established standards of perfection and excellence for drugs, appliances. We have established many councils which clarified the ethical standards of our own profession. We have modernized and set up standards of instruction and training that have made our profession without question the best educated. The American Medical Association has established in Chicago a headquarters worthy of our pride and esteem. Every member who visits Chicago should visit the Association building. He will go away edified and thrilled.

Michigan salutes a woman doctor and our own great headquarters.

MICHIGAN PROPOSES

THE FEDERAL Income Tax Acts as now applied make it almost impossible for a self-employed person, especially a professional person, to establish a financial program which will leave

him a secure income in his later years when his earning capacity is of necessity reduced.

Several times in our JOURNAL,* we have commented to the effect that the medical man and his professional confreres—the dentists, lawyers, architects and others who are self-employed—are handicapped because their training is long and costly. Their income-producing years are short and their income brackets are high. The present high tax arrangement prohibits laying aside a sufficient portion of their income to provide for the later years when their earning capacity has lessened. Others with longer income-producing years, earning just as much, but over longer periods and in lower brackets, pay much less.

We suggest that the Federal Government re-examine its present laws, and allow a self-employed professional person to invest up to 20 per cent of his net income in an approved endowment insurance policy or a specified low interest government bond designated by the Internal Revenue Department. The cost of this investment would be deductible as a business expense, but the income tax would be assessed at the time the endowment or the bond is cashed.

The government now allows industry and business to purchase endowment insurance for its higher executives, charging this cost to expense. The individual will have to pay the income tax when he receives his endowment insurance.

Our proposal gives the self-employed professional man the same benefit already given to other persons. We think it is just, we think it is our right. We propose that such legislation be enacted.

MEDICAL INCOMES

FOR MANY years surveys of medical incomes have been published which give an erroneous impression to the public of high incomes from the practice of medicine. The Council of the Michigan State Medical Society has believed that the publication of such reports and surveys in the past has not been for our best interests.

*Sept., 1945, page 1013; Sept., 1949, pages 1171-2; July, 1950, page 810; April, 1951, page 410.

EDITORIAL

The Editor has recently seen the results of a very exhaustive survey of the incomes and spending habits of a typical group of our own members whose incomes from their profession ranged from a minimum to a high of \$42,500. Averages only, were shown to us; and we were interested to learn that well over half of these incomes were under \$25,000, the largest number being in the \$20,000 group. Significant to us was the average cost of doing business, living expenses, et cetera, and particularly the small amount available for saving after taxes and contributions.

We believe a series of short articles on these studies would be most informative and have prevailed upon Messrs. Henry Black and Allison Skaggs, who made these studies, to prepare such articles for publication in *THE JOURNAL*. These gentlemen published several medical finance articles in our *JOURNAL* several years ago and stimulated much keen interest.

WAYNE UNIVERSITY MEDICAL SCHOOL

THE MICHIGAN State Legislature has been asked to appropriate sufficient funds to build a new science building for Wayne University. Much of the building now being used was old at the beginning of this Century. It is completely antiquated and actually unsafe for school purposes.

Michigan needs to educate its own doctors of medicine. We cannot expect our young men who wish to study medicine to be accepted in schools of other states when we will not accept students from other states in our schools. Wayne accepts no foreign students and the University of Michigan a very minimal number.

Michigan is now depending upon migration from other states to fill our medical needs. The City of Detroit has accomplished wonders in conducting and equipping a good medical school. Students are accepted from throughout the state, and the State Legislature has recognized its partial responsibility to Wayne University by an appropriation for planning made last year. There should be no hesitancy now and no delay in making an adequate science building available.

Funds were granted a year ago to the University of Michigan for such a building. Wayne University's needs are even greater, and such a grant could increase the number of doctors of medicine graduated very materially.

A word to our Representatives and Senators

would help. Most of our doctors know their Senators and Representatives sufficiently well that their expressed opinion will be favorably received.

ON THE RUN

Livestock bitten by rabid carnivores are unlikely to develop the disease and may be safely slaughtered within one week or after six months. The only risk is to the handlers of the live animal or carcass, not to the consumer.

* * *

Methemoglobinemia in infants from nitrates in well water can be relieved promptly by intravenous methylene blue solution 1 to 2 mg. per kg.

* * *

Acanthosis nigricans appearing in the axilla or groin may be a sign of internal cancer in adults but not in children . . .

* * *

A distensible organ subjected to prolonged strain ultimately loses its elasticity.

* * *

Iron deficiency is most likely to occur in menorrhagia, functional, fibroidal or menopausal, bleeding peptic ulcer, hemorrhoids, miscarriage or postpartum bleeding, parasitic infestation or bleeding from malignancy of excretory organs.

* * *

More liver damage may follow infectious hepatitis than cirrhosis.

* * *

Cation exchange resins offer a supplementary treatment for edema, tending to produce acidosis in contrast to the alkalosis induced by the mercurial diuretics.

* * *

The bearing of several large infants may presage the development of diabetes in the mother.

Selected by W. S. REVENO, M.D.

TAX AGENTS CHECK UP ON ONE OF EVERY TWELVE RETURNS

The chances are about one in twelve that the income tax return you must make as an individual will be scrutinized to be sure you paid enough.

That is, if you are in the so-called lower brackets.

If you make more than \$25,000, the odds are even that Federal agents will examine your return.

These Internal Revenue Bureau policies were revealed to the House Appropriations Committee during hearings on the 1952 Treasury appropriation bill.

Bureau officials said:

On returns of from \$7,000 to \$10,000, examinations are made of 8.80 per cent; from \$10,000 to \$25,000, it's 17.2 per cent; from \$25,000 to \$100,000, the percentage is 58.1; on \$100,000 and over, 85.4 per cent are examined.

Those are figures on checks of 1948 returns.

On returns of \$25,000 and over, the examinations have disclosed that seven out of every 10 have been in error. So, starting this year, every return in the big-bracket group will be audited once every two years.

All returns, regardless of size, are "scanned" for mathematical errors.

All in all, said the Internal Revenue Bureau, 95 per cent of American taxpayers are honest. The errors they make are not dishonest errors.—*Detroit Free Press*, March 15, 1951.

Dr. Powers to Receive Northwestern Award

Another outstanding award is coming to Dr. Lunette I. Powers, of Muskegon, "Michigan's Foremost Family Physician of 1950."

Dr. Powers has been chosen by Northwestern University Alumni to receive the award of the year for distinguished service among its thousands of alumni. She is to return to receive the honors during the Illumination Night ceremonies.

Frederick Merrifield, M. D., chairman of the Achievement Committee, of Northwestern alumni, and G. Willard King, the director, in a letter to the Muskegon physician today said:

"You have been chosen from thousands of Northwestern University Alumni to receive the merit award from the Alumni Association 'in recognition of worthy achievement.'"

The letter closed with, "Please accept our heartiest congratulations. We are indeed proud of you."

Dr. Powers was graduated from the Northwestern Medical School in 1897 at the age of 22. Her record at the university brought her an internship at the hospital.

Legislators Honor Dr. Powers
Adoption by the House of Representatives of the state legislature of a resolution offered by Representative Louis H. Freye of Muskegon, congratulating Dr. Lunette I. Powers of Muskegon on recently being chosen "Michigan's Foremost Family Physician" for 1950 by the Michigan State Medical Society, is the latest honor to be bestowed on the community's veteran woman physician.

MUSKEGON WOMAN DOCTOR RECEIVES STATE RECOGNITION
DETROIT, Dec. 7 (AP)—Michigan medicine paid its highest honor today to a woman.
Motherly-looking Dr. Lunette I. Powers of Muskegon, at 75 still in practice, was chosen "Michigan's foremost family physician for 1950."

The Michigan State Medical Society gave Dr. Powers its proudest citation for her service of more than half a century to the healing arts.

Dr. Powers has spent most of her career in Muskegon.

She was honored in the society's award as "the true family doctor, a personification of all the medical profession stands for."

Never marrying, she has given her life to her profession.

Nonetheless, children have been a big part of her life. She is credited with having helped to bring 5,000 Muskegon babies into the world.

Muskegon Woman, 75, Named State's 'Foremost Family Doctor For 1950'

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Muskegon Is Proud

As most of us know, "Michigan's Foremost Family Physician" for 1950 will be a resident of Muskegon, for Dr. Lunette I. Powers of this city has been accorded this year's annual award of the Michigan State Medical Society.

From all the doctors of the state, she was singled out as most deserving the title. Those who know her can easily understand and, the real pleasure is that so wide an area have also her unusual record of service.



Dr. Lunette I. Powers

There is nothing new in Dr. Powers and furthermore she is a woman who knows how to put them in practice. Practicing in Muskegon for 58 years, she has had high recognition from local physicians, from Northwestern University and previous Michigan State Medical Society itself. Her sense of duty and her sense of service to her profession are well known to local residents.

Her attitude is summed up in the remarks she made in receiving the new state award. "I do not deserve this great honor but by myself, with the full

Deserving Of Honor

MICHIGAN'S doctors apparently made a splendid decision in naming Dr. Lunette I. Powers, 75-year-old woman practitioner from Muskegon, as "Michigan's foremost family physician for 1950."

Dr. Powers, one of the first woman doctors in the state, has been practicing since she was 22, when she graduated from medical college at Northwestern University.

There has been nothing spectacular in her career, although she can undoubtedly claim sort of a record for having officiated at some 5,000 childbirths. She has just been a good, kindly, understanding family physician. Until recent years when younger doctors took over this task for her, she never shirked night calls in the line of duty. She never married. Her life was dedicated to medicine. She has made several trips abroad to keep abreast of the latest medical knowledge.

SHE has, apparently, never wanted to be anything but a good doctor. Her home community, Muskegon, and her alma mater, Northwestern University, have recognized her with numerous honors.

It was a fitting honor which the Michigan State Medical Society accorded her in her 75th year, which found her still active in her profession in the 53rd year of her practice. It is not given to many physicians—or citizens in any line of endeavor—to attain a record of more than half a century of service. It must be heart-warming to Dr. "Nettie" Powers to realize that her colleagues have recognized her devotion to duty and have called it to the attention of the entire state. She modestly can't understand "how this honor ever came to me." That modesty seems to be further proof that she is deserving of it.

Some of the Hundreds of Newspaper Clippings Honoring "Michigan's Foremost Family Physician for 1950"

Michigan's Foremost Family Physician for 1950

A True Exponent of the "Golden Rule"

THE DOCTORS of Michigan and the citizens of this state are more and more being made aware of the personality selected by them as "Michigan's Foremost Family Physician" for 1950—for in the few short months which have elapsed

is one that becomes, without question, a personification of the "Golden Rule."

A true "family doctor," she is all that the medical profession stands for. When notified of her new honor, she unselfishly said, "That I do not



AWARD PRESENTATION

Left to right: MSMS Secretary L. Fernald Foster, M.D., Bay City; Awardee Lunette I. Powers, M.D., Muskegon; MSMS President C. E. Umphrey, M.D., Detroit.

since announcement of the award, Lunette I. Powers, M.D., Muskegon practitioner for more than fifty years, has been honored and acclaimed throughout the state and nation.

The latest accolade accruing to the energetic "Grandmother of Medicine" is that to be conferred upon her by the Alumni Association of her Alma Mater, Northwestern University. On June 7, the kindly, gray-haired general practitioner will receive the 1951 Award for Distinguished Service from Frederick Merrifield, M.D., Chairman of Achievement Committee of Northwestern Alumni.

The career of the 75-year-old practitioner which began the year before the Spanish-American War

deserve this great honor is fully felt by myself, with the full realization that were it not for the considerate, courteous and kindly helpfulness of all my associates and friends, this great joy would not be mine today."

In addition to this award, the kindly lady doctor has been honored on many occasions. The Michigan State Legislature, during its current session, paid honor by adopting a concurrent resolution recognizing her great contributions to humanity through an unequalled life of unselfish service. Her first half-century of medical practice was noted in 1947 when she was elected to membership in the "50-Year Club" of her state medical society and

MICHIGAN'S FOREMOST FAMILY PHYSICIAN

also received a similar certificate from the Muskegon County Medical Society. Also in 1947, Dr. Powers was presented a Golden Reunion Certificate by her Alma Mater, Northwestern University.

confining classrooms behind, the 22-year-old "up-start" took the examinations leading to an internship at Chicago's famed Mary Thompson Hospital. She finished second among those competing

Michigan's Foremost Family Physician Award

for the year
1950
is presented to

Lunette H. Powers, M.D.
Muskegon, Michigan

For valued service rendered to the health of the people of Michigan in more than a half century of General Practice and for constant constructive effort to improve her profession. ~ ~

Awarded this fourteenth day of March 1951 by the

Michigan State Medical Society

C. E. Humphrey, M.D.
C. E. Humphrey, M.D.
President
H. Kernal Foster, M.D.
H. Kernal Foster, M.D.
Secretary

With a smile of reminiscence in her eyes, Doctor Powers told of the trials and tribulations that were hers in the struggle to complete her studies in the "no woman's land" of her day. Her interest in medicine, however, was deep rooted, having been born of an ancestry which included a grandfather and great-grandfather who were doctors of medicine. Her ambitions were furthered still by parents who were lifelong pharmacists and close friends of the medical profession.

Medical studies successfully completed, young Doctor Powers graduated from Northwestern University Medical School in 1897. Then, leaving

and after a period of time left for further internship in the Detroit Woman's and Children's Hospitals. Doctor Powers, in explanation of her internship, said, "The move wasn't necessary nor required at that time but being so young, I hesitated entering private practice until I had secured more seasoning and experience."

In 1900, Muskegon's first woman doctor hung out her shingle in competition with the male practitioners of that area and since that day has been closely associated with the growth and life of this Michigan community.

Her life has been one of complete sacrifice and devotion to duty and today after more than fifty-

MICHIGAN'S FOREMOST FAMILY PHYSICIAN

three years of active service, this kindly, benign doctor answers calls for help whether it be day or night. Her younger associates, however, in deference to her seniority and years, insist on caring for the majority of her night calls, although Doctor Powers has no trouble recalling the "times in years gone by when I would be returning from a round of night calls just as the sun was coming up."

A great, consuming love for her profession has always taken the time necessary for marriage, but the friendly doctor has many times experienced the thrill of family life, for by her own estimate, she has delivered more than 5,000 Muskegon residents into the world.

A close friend of famed Dr. Bertha Van Hooten, Chicago surgeon and author of the best seller, "Petticoat Surgeon," Doctor Powers has traveled in many foreign lands searching for additional knowledge of her art. Both women physicians toured England, Scotland and Ireland in 1937, making a careful study of the hospitals and clinics in these lands. Doctor Powers went south of the border in 1947 to attend a meeting of the Woman's International Medical Association in Mexico City.

An avid follower of medical events, the Muskegon doctor is a perennial attendant at meetings of her County Medical Society, the Michigan State Medical Society and the American Medical Association. She also maintains an active interest in civic affairs and is one of the founders of Muskegon's Quadrangle Club, a group of women devoted to furthering their professional and cultural associations.

Doctor Powers, who served as the first Chief of Obstetrics at Muskegon Hackley Hospital, still carries on there as a staff member as well as at nearby Mercy Hospital.

Typical of the hurried and busy life she leads after three-quarters of a century was Doctor Powers' acknowledgment of her MSMS honor. Hastily penned on a dinner napkin as she rode between her hospitals in Muskegon, the note read: "I wish it were possible to tell you in a more forceful manner how very appreciative, grateful and happy I am. How could this award ever come to me?" And while the good doctor wonders, many thousands of her friends and patients in Muskegon and throughout the land truly know why she was singled out to be the selection of

Michigan's medical profession as "Michigan's Foremost Family Physician" for 1950.

COMMON GERIATRIC DERMATOSES

(Continued from Page 500)

visceral diseases is of special importance in the management of dermatitis affecting elderly persons. Hormone therapy may be helpful in senile pruritus, and intramuscular injections of crude liver extract and administrations of vitamin B complex are often beneficial in seborrheic dermatitis. Existing anemia should be treated, and the diet should be adequate and properly balanced. The diet of an elderly person is often too high in carbohydrates. This is particularly true of elderly patients with seborrheic dermatitis.

Basic principles in the management of common types of dermatitis are the same for all age groups. However, degenerative changes of senile skin and other biologic changes incident to aging alter the clinical course of dermatitis in patients past sixty years of age. Satisfactory response to the treatment will depend, among other things, upon thorough evaluation of the physical and functional status of the patient, the perseverance of the physician and the co-operation of the patient.

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I know that the backers of the national health plan in this country resent the term "socialized medicine." They have all sorts of arguments to "prove" that doctors and patients will remain free as the air under their program. They make a strong case. Perhaps if human nature were less ornery and less aviricious, an idealistic health program might work out all right. But so long as people have preferences, so long as Park Avenue has more appeal than Hell's Kitchen, there will be an uneven distribution of doctors under any plan that does not contain compulsion. And once compulsion enters the picture, the rights and freedoms of all citizens stand in jeopardy. To me it is as simple as that. For forty years I have fought communism tooth and toenail because I do not want anyone pushing me around. I certainly do not want to put my head into a socialization noose voluntarily when the results can be as undesirable as communism.—WILLIAM L. HUTCHESON, *Gen. Pres. Brotherhood of Carpenters and Joiners, and Vice-Pres.*, A. F. of L., Cleveland, Dec. 6, 1950.



ELMER L. HENDERSON, M.D.
President
American Medical Association

To the Physicians of Michigan

This message is to commend you, the physicians of Michigan, for the superb manner in which you continue to serve the people of your state—guaranteeing them not merely the minimum of medical care, but actively endeavoring to secure for them the blessings of good health.

Because you, as individuals and as a state society, recognize that good health is the doctor's responsibility—not the government's—you have initiated many successful medical activities. Of special note are your Michigan Medical Service Plan, one of the world's largest voluntary health and medical service programs; your CAP Public Education Campaign; your Mediation Committee to hear complaints; your aggressive cancer, rheumatic fever, and rural health projects.

Through your community-minded professional efforts, you are joining America's doctors—and in many instances leading the way—in the campaign to keep American medicine free of government controls. Your continued efforts to boost Michigan's health will help America maintain her high standards of medical care which today are the best in the world.

(Signed) **ELMER L. HENDERSON, M.D.**
President, American Medical Association

Into the Second Century With the American Medical Association

THE AMERICAN MEDICAL ASSOCIATION is in the second century of its history, carrying on in the interest of the nation's health.

It was founded on May 5, 1847, when 250 delegates representing more than forty medical societies and twenty-eight colleges, embracing medical institutions in twenty-two states and in the District of Columbia, met in the hall of the Academy of Natural Sciences, Philadelphia. Dr. Nathaniel Chapman of Pennsylvania was elected first president.

From that small beginning, the American Medical Association has grown to become the largest medical organization in the world. It has more than 145,000 members. Of these, more than 81,000 are Fellows. There are more than 2,000 constituent county, parish or district societies in its makeup.

The AMA is a non-profit institution. Its purposes are to promote the science and art of medicine; to organize the medical profession and safeguard its worthy interests; to elevate the standard of medical education and practice, and to bring about the enactment of uniform legislation for the public welfare and to protect the public health.

At the very beginning of its existence, the American Medical Association began to war on quackery. A resolution was introduced at the organizational meeting condemning the practice then of allowing the untrained to engage in apothecaries and urging the establishment of schools of pharmacy. It also attacked the universal traffic in secret medicines and nostrums.

This war has been carried on relentlessly and the association more than any other agency in the country can take credit for the vast improvement that has occurred.

Public Benefits from Services

The marvelous advancements in medical science during the last century have helped to build the American Medical Association, which educates its members through meetings, exhibits, its many periodicals, its councils and committees and in other ways. The benefits of these activities are passed on to the public—the ultimate consumer.

In the course of time, the AMA has developed a large number of activities, all of which directly or indirectly have contributed to the outstanding health record of this nation.

The tremendous advance in scientific and technologic discovery within the last century has been rivaled only by the rapidity with which such discoveries have been adapted to medical uses. The practice of medicine is still an art as well as a science, and the scientific aspects of medicine place a heavy burden of responsibility on the individual physician and the American Medical Association.

In giving the patient the best that medical science has to offer, the practicing physician requires not only a long, expensive and exacting period of study and training, but he must continue throughout his career to have information on the latest discoveries in medicine.



The eight-story headquarters of the American Medical Association at 535 North Dearborn Street, Chicago, with some of the more than 800 employees who work there. Courtesy *Look* magazine.

INTO THE SECOND CENTURY

Few persons have time personally to evaluate new medical agents, foods or therapeutic aids. In this, as in many other matters, the doctors must look to a specializing committee or bureau, and to the collective opinion of experts.



George F. Lull, M.D., Secretary and General Manager of the American Medical Association. Courtesy, *Look* magazine.

Moreover, with technologic and scientific advance, new specialties have arisen which bring with them questions of policy, qualification and preparation. On these questions, as on many others relating to the scientific aspects of medicine, there must be agreement, order and exchange of information among physicians.

To accomplish these services, the AMA has developed working councils and bureaus. They are the Council on Medical Education and Hospitals, Council on Pharmacy and Chemistry, Council on Foods and Nutrition, Council on Physical Medicine and Rehabilitation, Council on Scientific Assembly, Therapeutic Trials Committee, Committee on Cosmetics, Committee on Therapeutic Research, Committee on Pesticides, Bureau of Investigation, Bureau of Exhibits, Chemical Laboratory and Microbiologic Laboratory.

Evaluate Medical Schools and Hospitals

The Council on Medical Education and Hospitals was organized in 1904 to improve the quality of medical education. Since then, largely through the efforts of the Council, the standards of medical education in the United States have been raised to the point where they are generally recognized to be the best in the world.

The Council on Pharmacy and Chemistry was organized in 1905 to protect the medical profession

and the public against quackery in the social aspects of medical practice, and against fraud, undesirable secrecy and objectional advertising in connection with proprietary medicines.

However, the Council's scope has been broadened to include the preparations of special treatises, articles, reports on the status of certain medicines, and books designed for the practitioner and medical student.

Provide Aid in Therapeutic Research

Two standing committees of the Council—Therapeutic Trials and Therapeutic Research—are well known for their contributions to research.

The Therapeutic Trials Committee is devoted to the encouragement of research on medical agents and the promotion of adequate treatment through a better understanding of the limitations of drugs and allied products.

That committee also organizes impartial clinical trials of biological and pharmaceutical agents which show promise of being good in either diagnosis, prevention or therapy. It also sponsors and co-ordinates co-operative clinical investigations, involving a number of institutions.

The Committee on Therapeutic Research encourages scientific investigations in the field of therapeutics by providing funds for the prosecution of necessary research.

The Committee on Pesticides of the Council on Pharmacy and Chemistry was formed in 1950. It began its activities with a six-point program for insecticides, fungicides, rodenticides, herbicides and similar types of economic poisons. This program involves: (1) Promotion of safe standards of use; (2) development of antidotal measures; (3) stimulation of voluntary control by the industry; (4) standardization of nomenclature; (5) accumulation and evaluation of new information, and, (6) undertaking of an intensive program of public education on usefulness and limitations of these agents.

Organized in 1929, the Council on Foods and Nutrition evaluates the nutritional claims of food products processors. The Council appraises voluntarily submitted foods, accompanied by complete advertising and information on ingredients, manufacturing process, bacteriologic examination and assurance of compliance with food laws.

Physical Devices Investigated

The Council on Physical Medicine and Rehabilitation was organized in 1925 as the Council on

INTO THE SECOND CENTURY

Physical Therapy. Its purpose is to gather and disseminate such information as will assist the medical profession in determining the therapeutic and diagnostic value of certain physical devices and methods employed in the practice of medicine.

The Committee on Cosmetics was organized in 1948 to provide information on cosmetics and other

Medical Publications Recognized World Over

The publications of the American Medical Association are recognized the world over for their contribution to medical knowledge. These periodicals reflect not only the advancements in medical science but every phase of medical interest.

In the forefront is *The Journal of the AMA*,



A typical scene during the annual session of The House of Delegates of the American Medical Association. Courtesy, *Look* magazine.

toilet goods preparations. The committee evaluates and accepts cosmetics that conform to its rules. A Seal of Acceptance is issued to the products which pass.

Bureau Wars Against Quackery

Another aid in the war on quackery was set up in 1906 with the establishment of the Bureau of Investigation. This serves as a clearing house of information on "patent" and over-the-counter medicines and related sundries, all forms of quackery, medical fads and fakes. Its files contain over 500,000 cards which are kept up to date.

The information is available to physicians, their patients, students and educators, government agencies and civic groups. The functions of the bureau are wholly educational in character, not punitive.

established in 1883 and now with a weekly circulation of more than 135,000. This is supplemented by nine specialty journals, covering the following subjects: Internal Medicine, Diseases of Children, Neurology and Psychiatry, Surgery, Dermatology and Syphilology, Otolaryngology, Pathology, Ophthalmology and Industrial Hygiene and Occupational Medicine. These monthly publications were established at various times beginning in 1909.

One of the outstanding medical libraries of the world is maintained for the benefit of members of the Association. A member wishing the latest literature on a medical subject which concerns one of his patients is immediately sent a package of material on the subject.

Promotes Social-Economic Aspects

The social and economic aspects of the practice of medicine have attained far-reaching implications. The physician is concerned with these implications as they reflect on the patient, the public and the profession.

Acting collectively for the individual physician, the American Medical Association, through its councils, committees and headquarters facilities, makes continuing study of activities, progress and trends in the socio-economic field of medicine.

The councils, committees and headquarters staff:

1. Assist the profession in keeping abreast of changes and trends in the socio-economic field of medicine.
2. Assist the patient in his search for ways and means of providing himself with medical care.
3. Assist the public in understanding the medical profession, and the quality and the value of the individual physician's services.
4. Bring together the public, the patient and the profession in the solution of the social and economic problems of medical care.

In 1873, the Judicial Council of the Association was organized to deal with matters concerning professional ethics. It is now becoming realized that the ethical standards which have been maintained and defended by the medical profession have been and remain among the greatest safeguards to the public health.

These ethics tend constantly to improve the quality of medical practice and to discourage dishonesty, charlatanism, quackery, undue personal ambition, destructive commercialism and other undesirable influences.

Legislative Bills Evaluated for Soundness

Established in 1922, the Bureau of Legal Medicine and Legislation performs a function of vital interest to the physician and the public. Everyone has a stake in soundly conceived legislation relating to medical care. The total of bills introduced in the state legislatures and Congress each year numbers in the thousands. Some bills are soundly conceived; others are not.

The Council on Medical Service was formed in 1943 to study the effect of the rapid social and economic changes on the problems of medical care. In carrying out its functions, the Council suggests means for improving the distribution of medical services and works with interested groups in such

improvement. The Council encourages a broadening of the voluntary health insurance program and awards its Seal of Acceptance to those voluntary prepayment medical plans which meet certain basic standards.

In 1938, the Council on Industrial Health was organized to assist the medical profession in developing and maintaining a high standard of health in industry. One of its purposes is to encourage broader participation in the expanding field of industrial health and medicine.

The Bureau of Health Education, organized in 1910, serves the public and the profession through literature, radio and television programs and other educational means. One of its most important activities is a program in school health and physical fitness.

Rural Health Advanced

To deal with the problem of maintaining an adequate supply of medical personnel and treatment facilities in rural areas, the Committee on Rural Health was organized in 1945.

In 1947, the Council on National Emergency Medical Service was established. This council is concerned with the medical and associated problems involved in the mobilization of our nation's civilian population in time of national emergency. Continuous co-ordinated study of the numerous problems associated with the mobilization of our nation's manpower resources and materials is required.

The AMA Public Relations Department aids the national, state and local medical societies in solving public relations problems, and helps the medical profession in building good will through public service.

The Bureau of Medical Economic Research was established in 1931 to study the economic aspects of the practice of medicine. Its activities include studies of the supply of and the demand for medical service. It carries on detailed research projects in medical economics.

In 1906, the AMA produced its first edition of the American Medical Directory, giving a biographical record of all physicians in the United States, its territories and Canada. The eighteenth edition, published in 1950, contains nearly 220,000 names.

The Woman's Auxiliary to the American Medical Association, organized in 1922, has a membership of nearly 50,000. The Auxiliary aids in the promotion of the health aims of the AMA.

Michigan State Medical Society

The 86th Annual Session



R. J. HUBBELL, M.D.
Kalamazoo
Council Chairman



C. E. UMPHREY, M.D.
Detroit
President



R. H. BAKER, M.D.
Pontiac
Speaker



L. FERNALD FOSTER, M.D.
Bay City
Secretary

OFFICIAL CALL
The Michigan State Medical Society will convene in Annual Session in Grand Rapids, Michigan, on September 24, 25, 26, 27, 28, 1951. The provisions of the Constitution and By-Laws and the Official Program will govern the deliberations.

C. E. UMPHREY, M.D.
President

R. J. HUBBELL, M.D.
Council Chairman

R. H. BAKER, M.D.
Speaker

J. E. LIVESAY, M.D.
Vice Speaker

Attest:

L. FERNALD FOSTER, M.D.
Secretary



J. E. LIVESAY, M.D.
Flint
Vice Speaker

TWO-DAY SESSION OF HOUSE OF DELEGATES, SEPTEMBER 24-25, 1951

The 1951 House of Delegates of the Michigan State Medical Society will hold a two-day session beginning Monday, September 24, at 10:00 a.m. The business of the House of Delegates will be transacted in the Ballroom, Pantlind, Hotel, Grand Rapids.

The House will also meet Monday at 2:00 p.m. and at 8:00 p.m. and on Tuesday, September 25, at 10:00 a.m. and at 8:00 p.m.

The intervals between meetings of the House of Delegates have been spaced to permit the Reference Com-

mittees ample time to transact all business referred to them.

Seating of Delegates

"Any Delegate-Elect not present to be seated at the hour of call of the first meeting may be replaced by the accredited Alternate next on the list as certified by the Secretary of the component County Society involved."—MSMS By-Laws, Chapter 8, Section 6.

Michigan State Medical Society

Past Presidents 1866-1950

- | | |
|--|---|
| <p>1866—*C. M. Stockwell, Port Huron
 1867—*J. H. Jerome, Saginaw
 1868—*Wm. H. DeCamp, Grand Rapids
 1869—*Richard Inglis, Detroit
 1870—*I. H. Bartholomew, Lansing
 1871—*H. O. Hitchcock, Kalamazoo
 1872—*Alonzo B. Palmer, Ann Arbor
 1873—*E. W. Jenk, Detroit
 1874—*R. C. Kedzie, Lansing
 1875—*Wm. Brodie, Detroit
 1876—*Abram Sager, Ann Arbor
 1877—*Foster Pratt, Kalamazoo
 1878—*Ed. Cox, Battle Creek
 1879—*George K. Johnson, Grand Rapids
 1880—*J. R. Thomas, Bay City
 1881—*J. H. Jerome, Saginaw
 1882—*Geo. W. Topping, DeWitt
 1883—*A. F. Whelan, Hillsdale
 1884—*Donald Maclean, Detroit
 1885—*E. P. Christian, Wyandotte
 1886—*Charles Shepard, Grand Rapids
 1887—*T. A. McGraw, Detroit
 1888—*S. S. French, Battle Creek
 1889—*G. E. Frothingham, Detroit
 1890—*L. W. Bliss, Saginaw
 1891—*George E. Ranney, Lansing
 1892—*Charles J. Lundy
 (Died before taking office)
 *Gilbert V. Chamberlain, Flint, Acting President
 1893—*Eugene Boise, Grand Rapids
 1894—*Henry O. Walker, Detroit
 1895—*Victor C. Vaughan, Ann Arbor
 1896—*Hugh McColl, Lapeer
 1897—*Joseph B. Griswold, Grand Rapids
 1898—*Ernest L. Shurly, Detroit
 1899—*A. W. Alvord, Battle Creek
 1900—*P. D. Patterson, Charlotte
 1901—*Leartus Connor, Detroit
 1902—*A. E. Bulson, Jackson
 1903—*Wm. F. Breakey, Ann Arbor
 1904—*B. D. Harison, Sault Ste. Marie
 *Deceased.</p> | <p>1905—*David Inglis, Detroit
 1906—*Charles B. Stockwell, Port Huron
 1907—*Hermon Ostrander, Kalamazoo
 1908—*A. F. Lawbaugh, Calumet
 1909—*J. H. Carstens, Detroit
 1910—*C. B. Burr, Flint
 1911—*D. Emmett Welsh, Grand Rapids
 1912—*Wm. H. Sawyer, Hillsdale
 1913—*Guy L. Kiefer, Detroit
 1914—*Reuben Peterson, Ann Arbor
 1915—*A. W. Hornbogen, Marquette
 1916—*Andrew P. Biddle, Detroit
 1917—*Andrew P. Biddle, Detroit
 1918—Arthur M. Hume, Owosso
 1919—*Charles H. Baker, Bay City
 1920—*Angus McLean, Detroit
 1921—*Wm. J. Kay, Lapeer
 1922—*W. T. Dodge, Big Rapids
 1923—*Guy L. Connor, Detroit
 1924—*C. C. Clancy, Port Huron
 1925—*Cyrenus G. Darling, Ann Arbor
 1926—J. B. Jackson, Kalamazoo
 1927—Herbert E. Randall, Flint
 1928—Louis J. Hirschman, Detroit
 1929—J. D. Brook, Grandville
 1930—*Ray C. Stone, Battle Creek
 1931—*Carl F. Moll, Flint
 1932—J. Milton Robb, Detroit
 1933—*George LeFevre, Muskegon
 1934—*R. R. Smith, Grand Rapids
 1935—Grover C. Penberthy, Detroit
 1936—Henry E. Perry, Newberry
 1937—Henry Cook, Flint
 1938—Henry A. Luce, Detroit
 1939—Burton R. Corbus, Grand Rapids
 1940—Paul R. Urmston, Bay City
 1941—Henry R. Carstens, Detroit
 1942—H. H. Cummings, Ann Arbor
 1943—C. R. Keyport, Grayling
 1944—A. S. Brunk, Detroit
 1945—*V. M. Moore, Grand Rapids
 (Died before taking office)
 1945—R. S. Morrish, Flint
 1946—Wm. A. Hyland, Grand Rapids
 1947—*P. L. Ledwidge, Detroit
 1948—E. F. Sladek, Traverse City
 1949—Wilfrid Haughey, Battle Creek
 (President-for-a-Day, Sept. 21, 1949)
 1949—W. E. Barstow, St. Louis
 1950—C. E. Umphrey, Detroit</p> |
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Michigan State Medical Society

The 86th Annual Session

Pantlind Hotel-Civic Auditorium, Grand Rapids, Michigan

September 26-27-28, 1951

INFORMATION

● **GRAND RAPIDS WILL BE HOST TO MSMS IN SEPTEMBER.**

● **THE PROGRAM OF THE ASSEMBLY** for the 86th Annual Session and Postgraduate Conference of the Michigan State Medical Society lists guest speakers from all parts of the United States. They are the usual stars in the medical world which always grace the annual conventions of the Michigan State Medical Society; they insure a valuable concentrated postgraduate course in all phases of medicine and surgery for the busy practitioners of Michigan, neighboring states and the Province of Ontario, on September 26-27-28, 1951.

● **REGISTRATION**, Tuesday afternoon through Friday afternoon, September 25-28, Civic Auditorium. Advance registration—on Tuesday and early Wednesday morning—will save your time. Present your State Medical Society or Canadian Medical Association membership card to expedite registration.

No registration fee for State Medical Society and CMA members.

Doctors of Medicine, who are not members of their state medical society or the Canadian Medical Association, will be accorded the privileges of the MSMS Annual Session upon payment of a \$5.00 registration fee.

Register as soon as you arrive. Admission by badge only.

● **ALL SUBJECTS** at the MSMS Annual Session are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.

● **POSTGRADUATE CREDITS** given to every MSMS member who attends MSMS Annual Session.

● **SIX ASSEMBLIES AND ONE PUBLIC MEETING**—fourteen Section Meetings—Twenty-four Discussion Conferences on September 26-27-28.

● **AMA PRESIDENT AT PUBLIC MEETING.** The General Meeting of Wednesday, September 26, 8:30 p.m.—Officers' Night—will be open to the public. In-

vite your patients and friends to hear John W. Cline, M.D., San Francisco, California, President, American Medical Association, Black and Silver Ballroom, Civic Auditorium, Grand Rapids.

● **PAPERS WILL BEGIN AND END ON TIME.** This scientific meeting will feature by-the-clock promptness and regularity.

● **ONE HUNDRED TWENTY TECHNICAL EXHIBITS** will contain much of interest and value. Intermissions to view the exhibits have been arranged.

● **J. DUANE MILLER, M.D., GRAND RAPIDS**, is General Chairman of the Grand Rapids Committee on Arrangements for the 1951 MSMS Annual Session.

● **CABARET-STYLE DANCE AND ENTERTAINMENT**, with the compliments of the Michigan State Medical Society, will be held in the Ballroom, Pantlind Hotel, Thursday evening, September 27. All who register, and their ladies, will receive a card of admission and are cordially invited to attend.

● **MSMS HOUSE OF DELEGATES** convenes Monday, September 24, at 10:00 a.m., Ballroom, Pantlind Hotel. It will hold three meetings on Monday, at 10:00 a.m., at 2:00 p.m., and at 8:00 p.m., also two meetings on Tuesday, September 25, at 10:00 a.m., and at 8:00 p.m.

● **THE WOMAN'S AUXILIARY** to the Michigan State Medical Society will present an attractive social and business program at the Pantlind Hotel, Grand Rapids. The wife of every MSMS member is cordially invited to attend.

● **MEMBERS OF MICHIGAN MEDICAL SERVICE** will meet in annual session, Tuesday, September 25, Ballroom, Pantlind Hotel, at 2:00 p.m., following the MMS luncheon at 1:00 p.m. in the Kent State Room.

A Scientific Exhibit will be featured at the 1951 MSMS Annual Session,
in the Civic Auditorium, Grand Rapids

SAVE AN ORDER FOR THE EXHIBITOR AT THE MICHIGAN STATE MEDICAL
SOCIETY ANNUAL SESSION

MICHIGAN STATE MEDICAL SOCIETY

The 86th Annual Session

Pantlind Hotel-Civic Auditorium, Grand Rapids
September 24, 25, 26, 27, 28, 1951

HOUSE OF DELEGATES—ORDER OF BUSINESS*

MONDAY, SEPTEMBER 24

Ballroom, Pantlind Hotel, Grand Rapids

10:00 a.m.—First Meeting

1. Call to order by Speaker.
2. Report of Committee on Credentials.
3. Roll Call.
4. Appointment of Reference Committees
 - (a) On Officers' Reports
 - (b) On Reports of The Council
 - (c) On Reports of Standing Committees
 - (d) On Reports of Special Committees
 - (e) On Constitution and By-Laws
 - (f) On Resolutions
 - (g) On Special Memberships
 - (h) On Rules and Orders of Business
 - (i) On Legislation and Public Relations
 - (j) On Hygiene and Public Health
 - (k) On Medical Service and Prepayment Insurance
 - (l) On Miscellaneous Business
 - (m) On Executive Session
 - (n) On Emergency Medical Service
5. Speaker's Address—R. H. Baker, M.D., Pontiac
6. President's Address—C. E. Umphrey, M.D., Detroit
7. President-Elect's Address—O. O. Beck, M.D., Birmingham
8. Annual Report of The Council—R. J. Hubbell, M.D., Kalamazoo, Chairman
9. Report of Delegates to American Medical Association—W. D. Barrett, M.D., Detroit, Chairman
10. Brief of Annual Report of Woman's Auxiliary President—Mrs. O. D. Stryker, Mt. Clemens
11. Selection of Michigan's Foremost Family Physician
12. Resolutions**.
13. Supplementary Report of Committee on Credentials

MONDAY, SEPTEMBER 24

Ballroom, Pantlind Hotel, Grand Rapids

2:00 p.m.—Second Meeting

14. Supplementary Report of Committee on Credentials
15. Roll Call
16. Report of MSMS Standing Committees
 - A. Committee on Postgraduate Medical Education
 - B. Preventive Medicine Committee:
 - (1) Rheumatic Fever Control Committee
 - (2) Cancer Control Committee (and sub-committees)
 - (3) Maternal Health Committee
 - (4) Venereal Disease Control Committee
 - (5) Tuberculosis Control Committee

*See the Constitution Articles IV, VII and XII, and the By-Laws, Chapter 8 on "House of Delegates."

**All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws Chapter 8, Section 10-m).

- (6) Industrial Health Committee
- (7) Mental Hygiene Committee
- (8) Child Welfare Committee
 - (a) Sub-Committee on Hearing Defects
 - (b) Sub-Committee of Ophthalmologists
- (9) Iodized Salt Committee
- (10) Geriatrics Committee
 - (a) Sub-Committee on Diabetes Control
 - (b) Sub-Committee to Study Problem of Caring for Aged
- (11) Committee on Infectious Diarrhea
- C. Committee on Distribution of Medical Care
- D. Committee on Public Relations (and sub-committees)
- E. Committee on Ethics
- F. Legislative Committee
- G. Legislative Study Committee

17. Reports of Special Committees
 - A. Beaumont Memorial Committee
 - B. Scientific Radio Committee
 - C. Advisory Committee to Woman's Auxiliary
 - D. Liaison Committee with State Medical Assistants Society
 - E. Advisory Committee to National Foundation for Infantile Paralysis
 - F. Committee on Increase of Medical Students Graduated from Michigan Medical Schools

Reports of the Committees of The Council, including Committee on Scientific Work, are included in the Annual Report of the Council

MONDAY, SEPTEMBER 24

Ballroom, Pantlind Hotel, Grand Rapids

8:00 p.m.—Third Meeting

18. Supplementary Report of Committee on Credentials
19. Roll Call
20. Unfinished Business
21. New Business†
22. Report of Reference Committees
 - (a) On Officers' Reports
 - (b) On Reports of The Council
 - (c) On Reports of Standing Committees
 - (d) On Reports of Special Committees
 - (e) On Constitution and By-Laws
 - (f) On Resolutions
 - (g) On Special Memberships
 - (h) On Rules and Order of Business
 - (i) On Legislation and Public Relations
 - (j) On Hygiene and Public Health
 - (k) On Medical Service and Pre-payment Insurance
 - (1) On Miscellaneous Business
 - (m) On Executive Session
 - (n) On Emergency Medical Service

†All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws, Chapter 8, Section 10-m).

86TH ANNUAL SESSION

TUESDAY, SEPTEMBER 25

Ballroom, Pantlind Hotel, Grand Rapids

10:00 a.m.—Fourth Meeting

23. Supplementary Report of Committee on Credentials
24. Roll Call
25. Unfinished Business
26. New Business
27. Supplementary Reports of Reference Committees

TUESDAY, SEPTEMBER 25

Ballroom, Pantlind Hotel, Grand Rapids

8:00 p.m.—Fifth Meeting

28. (Topic to be announced) by John W. Cline, M.D., San Francisco, Calif., President of the American Medical Association
29. Supplementary Report of Committee on Credentials
30. Roll Call
31. Unfinished Business
32. Supplementary Report of The Council
33. Supplementary Reports of Reference Committees
34. Elections
 - (a) Councilors
 - 1st District—L. W. Hull, M.D., Detroit—Incumbent
 - 4th District—R. J. Hubbell, M.D., Kalamazoo—Incumbent
 - 5th District—J. D. Miller, M.D., Grand Rapids, Incumbent
 - 6th District—R. C. Pochert, M.D., Owosso—Incumbent
 - (b) Delegates to American Medical Association
 - L. G. Christian, M.D., Lansing—Incumbent
 - W. A. Hyland, M.D., Grand Rapids—Incumbent
 - R. A. Johnson, M.D., Detroit—Incumbent
 - (c) Alternate Delegates to the American Medical Association
 - H. H. Cummings, M.D., Ann Arbor—Incumbent
 - E. C. Texter, M.D., Detroit—IncumbentAlso two other Alternate Delegates, so that each of the six Delegates has an Alternate
 - (d) President-Elect
 - (e) Speaker of House of Delegates
 - (f) Vice Speaker of House of Delegates

35. Adjournment.

MAY, 1951

LARGEST EXHIBIT IN MSMS HISTORY

The Exhibit Section at the MSMS Annual Session, Grand Rapids, September 26-27-28, 1951, will include the largest number of spaces in the history of the Society—139 booths. This is a greater exhibit than at many national meetings.

In some respects, this year's exhibit will be as interesting and desirable to doctors of medicine as the papers presented in the meeting room. The exhibit section will bring tangible values to those doctors of medicine who inspect it.

Have You Made Your HOTEL RESERVATIONS?

**MICHIGAN STATE MEDICAL SOCIETY
86th Annual Session
Grand Rapids, September 26-27-28, 1951**

E. J. Brunette, Secretary, Committee on Hotels,
Michigan State Medical Society 86th Annual Session,
c/o Pantlind Hotel, Grand Rapids, Michigan

Please make hotel reservation(s) as indicated below:

Hotel(1st choice)

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.....Single Room(s)

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Arriving September hour.....A.M.....P.M.

Leaving September hour.....A.M.....P.M.

(Names and addresses of all applicants including person making reservation.)

Name	Address	City	State
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Date Signature

AddressCity

TENTATIVE OUTLINE OF 1951 ASSEMBLY SPEAKERS

86th Annual Session, Michigan State Medical Society

Grand Rapids, September, 1951

Time	Wednesday September 26	Thursday September 27	Friday September 28
A.M.	Registration. Exhibits open.	Registration. Exhibits open.	Registration. Exhibits open.
8:30-9:00			
9:00-9:30	<i>Surgery</i> R. H. SMITHWICK, M.D. Boston	<i>Gynecology</i> A. C. BARNES, M.D. Columbus, Ohio	<i>Medicine</i> (Not decided)
9:30-10:00	<i>Medicine</i> SARA M. JORDAN, M.D. Boston	<i>Ophthalmology</i> D. B. KIRBY, M.D. New York City	<i>Dermatology & Syphilology</i> S. W. BECKER, M.D. Chicago
10:00-11:00	Intermission to View Exhibits.	Intermission to View Exhibits.	Intermission to View Exhibits.
11:00-11:30	<i>General Practice</i> (Not decided)	<i>Pediatrics</i> A. J. HORESH, M.D. Cleveland, Ohio	<i>General Practice</i> E. L. SEVRINGHAUS, M.D. Nutley, N. J.
11:30-12:00	<i>Dermatology & Syphilology</i> STEPHEN ROTHMAN, M.D. Chicago	<i>Public Health & Preventive Medicine</i> F. H. TOP, M.D. Minneapolis, Minn.	<i>Nervous & Mental Diseases</i> (Not decided)
P.M.			
12:00-1:30	4 Section Meetings <i>Dermatology & Syphilology</i> STEPHEN ROTHMAN, M.D. Chicago <i>Urology</i> A. I. DODSON, M.D. Richmond, Va. <i>Gynecology & Obstetrics</i> A. H. ALDRIDGE, M.D. New York City <i>Otolaryngology</i> H. L. WILLIAMS, M.D. Rochester, Minn.	6 Section Meetings <i>Pediatrics</i> A. J. HORESH, M.D. Cleveland, Ohio <i>Surgery</i> (Not decided) <i>Ophthalmology</i> D. B. KIRBY, M.D. New York City <i>Public Health & Preventive Medicine</i> F. H. TOP, M.D. Minneapolis, Minn. <i>Gastroenterology & Proctology</i> (Not decided) <i>Anesthesia</i> E. M. PAPPER, M.D. New York City	4 Section Meetings <i>Pathology</i> J. W. KERNOHAN, M.D. Rochester, Minn. <i>Medicine</i> (Not decided) <i>General Practice</i> (Not decided) <i>Nervous & Mental Diseases</i> Thomas V. Hoagland, M.D. Detroit
1:30-2:00	<i>Pediatrics</i> W. J. POTTS, M.D. Chicago	<i>Medicine</i> ALEXANDER MARBLE, M.D. Boston, Mass.	<i>Surgery</i> W. P. BLOUNT, M.D. Milwaukee
2:00-2:30	<i>Urology</i> A. I. DODSON, M.D. Richmond, Va.	<i>Gastroenterology & Proctology</i> Thomas T. Mackie Winston-Salem, N. C.	<i>Pediatrics</i> W. E. NELSON, M.D. Philadelphia
2:30-3:00	<i>Obstetrics</i> A. H. ALDRIDGE, M.D. New York City	<i>Anesthesia</i> E. M. PAPPER, M.D. New York City	<i>Pathology</i> J. W. KERNOHAN, M.D. Rochester, Minn.
3:00-4:00	Intermission to View Exhibits.	Intermission to View Exhibits.	Intermission to View Exhibits. 3:00-3:30 p.m.
4:00-4:30	<i>Otolaryngology</i> H. L. WILLIAMS, M.D. Rochester, Minn.	<i>Obstetrics</i> L. M. HELLMAN, M.D. Brooklyn, N. Y.	<i>Surgery</i> 3:30-4:00 p.m. O. T. CLAGETT, M.D. Rochester, Minn.
4:30-5:00	<i>Surgery</i> A. H. ALDRIDGE, M.D. New York City	<i>Surgery</i> C. A. MOYER, M.D. Dallas, Texas	<i>Medicine</i> 4:00-4:30 p.m. (Not decided)
5:00-6:00	Discussion Conferences.	Discussion Conferences.	Discussion Conferences. 4:30-5:30 p.m.
8:30-10:00	Officers' Night Biddle Lecture	10:30 p.m. State Society Night Entertainment	END OF ASSEMBLY

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RESEARCH IN THE SERVICE OF MEDICINE

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

The majority of Michigan's local health officers gathered in Lansing early in April at the invitation of the State Health Commissioner to make their recommendations for the continuation of the state health program. The three-day Commissioner's Conference of Health Officers resulted in thirty-six recommendations from the local health directors.

The local health officers recommended that local health departments assume responsibility and leadership for civil defense medical and health services; institute accident prevention programs; give continued attention to housing as a public health factor; promote county sanitary codes; and take more responsibility for training of public health personnel.

The health officers favored enlargement of health jurisdictions to include sufficient population to support an adequate public health organization.

They wanted restored most of the services of the Michigan Department of Health which had to be deleted because of budget cuts. Particularly they wanted routine Rh typing on all prenatal blood specimens submitted for Kahn tests; quantitative serologic tests upon request of physician or health officer, and additional quantitative serologic tests for control of treatment. They asked the restoration of the state tuberculosis X-ray services to their former level. They recommended that the State Department of Health consider employing one or more consultants in housing to aid local health departments, and that the State Health Department take the initiative in developing model environmental health ordinances.

The local health officers favored pre-school examinations for all entering children, and vision and hearing screening by the State Health Department at the request of the local health department. They recommended the deletion from the list of currently reportable diseases "the less common or the less dangerous" ones. They endorsed the fluoridation of public water supplies for prevention of dental caries and favored local health department supervision of municipal water supplies.

These and other recommendations to the Commissioner have been submitted to all local health officers of the state and to the Division Directors of the State Health Department for consideration and application in the state health program.

More than 700 additional public health workers are needed in Michigan to fill vacancies and to meet minimum standards set by the American Public Health Association. The recommendations call for one physician and one sanitarian for each 25,000 people in a state. This would mean that Michigan needs twenty-nine additional public health physicians and thirty-four additional sanitarians. To fill vacancies and provide public health nursing services according to the recommended

ratio of one nurse to every 5,000 people, an additional 647 public health nurses are needed to supplement those now employed by local agencies.

Background information and instructions for recording causes of death in proper sequence on the new form of death certificate is given in a new fifteen-minute sound film strip, "Medical Certification of Causes of Death," recently added to the Film Loan Library of the Michigan Department of Health.

The strip distributed by the National Office of Vital Statistics stresses the importance of proper sequence in classification of official mortality statistics particularly for measuring health and medical progress and planning health programs.

The strip is designed primarily for physicians and hospital personnel who fill out death certificates. Requests for use of the strip should be addressed to the Visual Education Service, Michigan Department of Health, Lansing 4, Michigan.

To extend the benefits of the vision services of the Michigan Department of Health to as large a share of Michigan school children as possible the vision consultant of the Department in co-operation with the teacher-training institutions of the state will conduct short courses to train local vision screening technicians during the summer. The local technicians usually employed by the local boards of education, service clubs interested in children, or health departments, do the initial screening in the vision testing program. Thirty-three such technicians were trained in summer courses last year.

Investigators assigned to the local health departments of the state by the Division of Tuberculosis and Venereal Disease Control who previously have worked primarily in Venereal Disease Control now are expediting local tuberculosis control programs. They assist local health departments and physicians in contact finding, case follow-up, work with recalcitrant patients, investigation of home facilities for the care of the patient eligible for release from a sanatorium and other tuberculosis control problems. Training in the tuberculosis control field was recently provided to the investigators in the Michigan Department of Health.

A copy of the 1951 revision of the Michigan Regulations for the Control of Communicable Disease soon will be mailed to each physician in the state. There is already one copy of the little "red book" in each local health department office.

Two articles on venereal disease control in Michigan are contained in the April, 1951, issue of the *Journal*

(Continued on Page 534)

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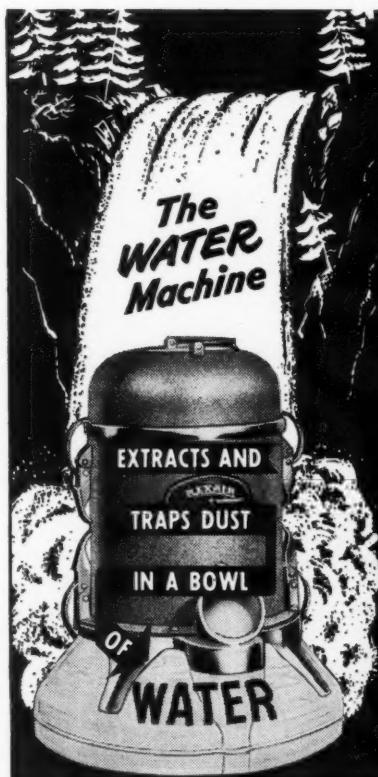
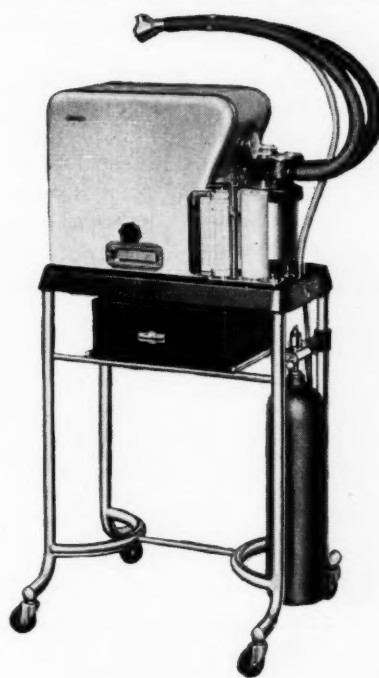
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Head Pain as a Diagnostic Lead

Frequently the presence of head pain is overlooked. The physician learns of it only if he has made an effort to elicit the information. Since the etiology of the pain is the basis of rational management, the patient should be warned against taking medication before diagnosis is made.

Friedman¹ deplores the tendency to call any chronic recurring headache migraine. Careful history-taking and full physical and neurological examinations are essential for accurate diagnosis. A good starting point is a description of the headache—its character, laterality, frequency and intensity.²

The following chart gives briefly the primary diagnostic leads and treatment for the most common types of headache.

Etiology of Headache	Primary Diagnostic Data	Primary Therapy
Inflammatory e.g., Meningitis Abscess	Inflammation of intracranial structures; fever; leucocytosis; bacteriologic diag.	Specific: sulfonamides and antibiotics. Symptomatic: analgesics.
Tumor	Pain varies as spinal press. changes; skull X-ray.	Specific: surgery. Symptomatic, analgesics &/or hypnotics.
Sinusitis	Sinus congestion and infection; cloudy X-ray.	Specific: antibiotics and drainage. Symptomatic: analgesics.
Hypertensive	Hypertension present but pain not related to b.p. level; Dihydroergotamine relieves pain.	General hypertension therapy; sedation. Symptomatic: analgesics.
Migraine & other vascular headaches	Headache: recurrent, intense, throbbing. No organic causation; migraine in family; patient: energetic, perfectionist. Visual prodromata; g.i. upset during headache.	To abort attack: oral ergotamine plus caffeine. General: adjustment to minimize nervous stress.

Data here tabulated is from: Wolf, G., Jr.,³ and Friedman, A. P.⁴

Cecil⁵ ranks vascular headaches, e.g., migraine and tension headaches, as the most commonly encountered of all. Because of their functional nature and usual recurrence at frequent intervals, they present a long-term therapeutic problem.

Therapy is conducted along two lines:

1) *Psychotherapy to reduce the frequency of attacks. This consists mainly of advice on emotional adjustment to stressful situations and guidance toward a good balance between work and relaxation.*

2) *Treatment of the distressing attack to prevent the usual period of incapacitation. Many investigators have reported that ergotamine preparations are effective for relief of the acute migraine attack in 80% of cases.^{1,6} The drug is given immediately when an attack is approaching and dosage adjusted to the needs of the individual.*

1. Friedman, A. P. and von Storch, T.: 99th A.M.A. Session, June 1950. 2. Butler, S. and Hall, F.: M. Clin. N. Amer., p. 1439 (Sept.) 1949. 3. Wolf, G., Jr.: M. J. 54:25, 1951. 4. Friedman, A. P. and Conn, H. T.: Current Therapy, 1950, p. 563; Saunders Co., Phila. 5. Cecil, R. L.: A Textbook of Medicine, ed. 7, 1948, p. 1483; Saunders Co., Phila. 6. Horton, B. et al: Staff Meet. of Mayo Clinic 20:241, 1945.

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(Continued from Page 532)

nal of Venereal Disease Information. They are: "A New Approach to Venereal Disease Education at Michigan Fairs" by John A. Cowan, M.D., Director of the Division of Tuberculosis and Venereal Disease Control, and "Control Serum in Serodiagnosis of Syphilis," by M. D. Kurtz, D.V.M., and E. M. Hill, M.S., of the Division of Laboratories.

May is Child Health Month in Michigan. The April issue of *Michigan Public Health* will carry articles on children's immunization, nutrition, hearing, vision, dental health, pre-school examination, mental health and poliomyelitis and nursery schools.

This Department is urging special attention to the home accident prevention aspects of the spring clean-up of home and grounds.

A total of 1,494 Michigan people were killed in home accidents in their own homes in 1949, while 1,493 were killed in traffic accidents in the same year.

Almost three out of four of the fatal home accidents were falls—falls from one level to another or tripping or stumbling. The great majority of those killed by falls were mature people. Fires were second in importance as a cause of fatal home accidents. They killed people of all ages.

Stressing that the householder usually knows of the hazard which endangers life in his home, the Department prepared a check list for spring clean-up of home accident hazards which was printed in the March issue of *Michigan Public Health*.

Freeman Hersey, M.D., former director of the Lenawee county health department, has been appointed Medical Co-ordinator of the state Civil Defense Program. He is responsible to the Office of Civil Defense through the State Health Commissioner. His offices are in the Prudden Building, Lansing.

E. J. Brenner, M.D., acting director of the Alger Schoolcraft District Health Department, has resigned. Mr. A. W. Heitman is now serving as acting director of the Department.

SENATE ARMED SERVICES COMMITTEE HEARINGS

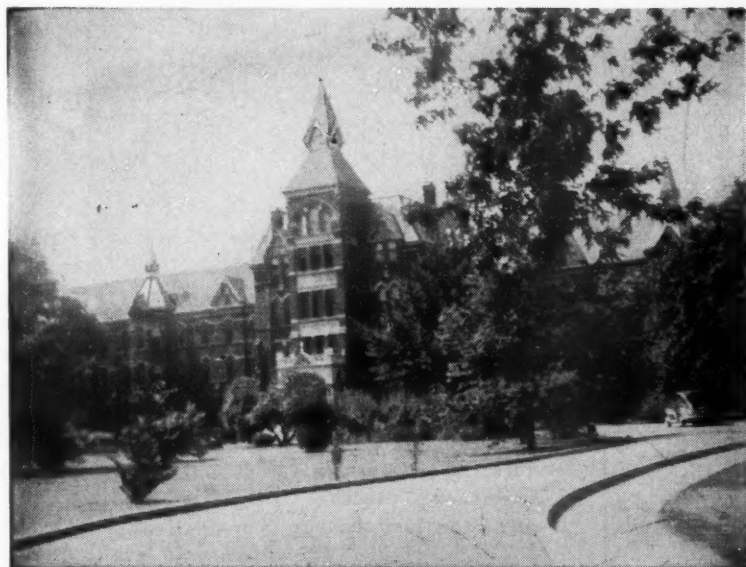
Proposals advanced at the committee hearings by Mrs. Rosenberg and Secretary Marshall include government-controlled selection of college students; a plan of Federal scholarships, and a plan of free medical rehabilitation for men with physical defects through the United States Public Health Service or Veterans Administration.

On this testimony there can be little doubt as to the plans to regiment the youth of America.—PAUL SHAFER.

JMSMS

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Wilfrid Haughey, M.D., Editor
Journal of the Michigan State Medical Society
610 Post Building
Battle Creek, Michigan

Dear Sir:

At this time I am making a preliminary report of a therapeutic procedure which may be of interest to the medical profession. In the *American Journal of the Medical Sciences* (211:448, 1946), T. and J. Gillman from the union of South Africa reported the efficacy of Speransky's spinal pumping procedure in producing complete remissions in rheumatic fever cases which were refractory to all other therapeutic measures. Some of these cases had skin rashes and acne which cleared following this procedure. I want to report the following cases and their results.

The first was a fifty-six-year-old white man who had rheumatoid arthritis which was in an activated state. He also had a mild seborrheic dermatitis across the bridge of his nose extending onto both malar areas. The spinal pumping procedure was carried out exactly as described by the Gillmans. There was no change in the status of the arthritis, but the dermatitis completely cleared within one day. There were no changes in the eosinophil counts done before and four hours after the pumping procedure.

The second case was that of a thirty-two-year-old white woman who developed psoriasis on the legs at the age of four and has had it since. When she got rheumatoid arthritis at the age of fourteen, the psoriasis became more widespread over the body, including the face. This had never cleared completely on any regimen. In December, 1950, she was treated in the Hospital with ACTH for nine days. At this time only her legs had some weeping lesions. These promptly dried and the arthritic pains disappeared. After nine days on ACTH, she was sent home on cortisone orally. After two weeks it was stopped because she became depressed and had fullness of the face. While still on this, the psoriatic lesions began to recur and then became generalized over the whole body surface, arms, legs, and face.

On March 13, 1951, she was re-admitted to the hospital. The skin was very scaly, a deep red color, pruritic, and fissured with weeping. Her temperature was 101 at 4 P.M. and 101.5 at 8 P.M. On March 14, at 8 A.M., her temperature was 98.5. Speransky's spinal pumping procedure was carried out. This was uneventful. At 4 P.M. her temperature was 101.5, and she had a severe headache. At 10 P.M. her temperature was 103, and she was still feeling poorly because of the headache. The skin, however, was feel-

(Continued on Page 538)



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(Continued from Page 536)

ing better as there was no more pruritus present and it felt drier. On March 15, the skin was dry, no pruritus was present, and the deep red color was fading. The fissures in the antecubital fossae were gone. The joints were aching a little more than when she entered the hospital. On March 16 she was feeling better and eating better. The skin was dry and now was pink in color. There was some peeling of the skin. On March 17 the skin was peeling in large sheets. In these areas the skin was smooth, thin, and pink and had a burning sensation. Her general condition was improved except for the joint pains for which she was given nucorsal 2 tablets q.i.d. These gave some relief. Vaseline was placed over the skin b.i.d. The skin continued to improve daily. It now has only a pink color and is smooth except on the arms where there is still some peeling. There are no lesions of psoriasis present anywhere on the body. The patient stated that her skin had never cleared as rapidly or as completely as it has this time.

After the first day, the temperature never was higher than 99.6, and usually was only 99. The arthritis was unrelieved during this period of observation. She was placed on ACTH again without relief of the joint pains. The spinal fluid, which was removed at the end of the pumping procedure, had the following findings: 2 lymphocytes, sugar—55 mg. per cent, protein—12 mg. per

cent, and Pandy—negative. These findings do not indicate any acute irritation to the meninges to have occurred.

Another case of rheumatoid arthritis in a middle-aged man underwent this procedure without incident and without any benefit to his inflamed joints.

Although there are only two cases reported at this time, in view of the studies that have been carried out with ACTH and cortisone on skin and rheumatic fever disease states, it was thought that this report would interest others working in these fields. If the work of Speransky and the Gillmans on rheumatic fever, and the Gillmans and this on some types of skin diseases are substantiated, there will be a new approach to the study of these conditions. One may venture to ask whether this procedure stimulates the pituitary-adrenal axis to greater activity by a milking action on the pituitary gland, thereby precipitating a remission. Whatever the answer may be, other cases are being studied and will be reported upon later.

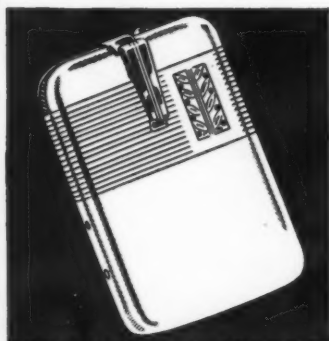
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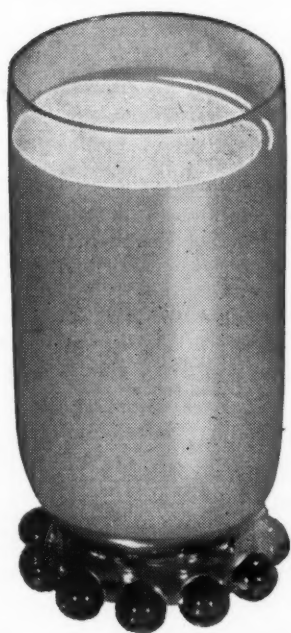
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NEWS MEDICAL

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION

GRAND RAPIDS—September 26-27-28, 1951

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

June 5	St. Clair County Medical Society's Clinic Day. Black River Country Club
June 22-24	Upper Peninsula Medical Society Annual Meeting
July 26-27	Annual Collier-Penberthy Medical-Surgical Conference (sponsored by Grand Traverse - Leelanau - Benzie County Medical Society) Traverse City
Sept. 26-27-28	MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION Grand Rapids
October 12	Third Michigan Cancer Conference East Lansing
Autumn	MSMS Postgraduate Extramural Courses State-wide
Oct. or Nov.	American Academy of General Practice of Wayne County Detroit
November 7	Clara Elizabeth Fund Lectures (sponsored by Genesee County Medical Society and the Clara Elizabeth Fund for Maternal Health) Flint

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

* * *

Corrections: S. W. Hartwell, M.D., of Muskegon was listed in error (on page 342 of March JMSMS) as Chairman of Committee on Emergency Medical Service. This should have read H. L. Gordon, M.D., of Detroit, Michigan.

Author John J. Grebe, Ph.D., is from Midland, Michigan, not Midland, Washington (page 271 of March JMSMS).

* * *

F. A. Collier, M.D., Ann Arbor, was presented with the Buffalo Surgical Society "Roswell Park Memorial Medal" for outstanding surgical achievement on February 15, in Buffalo, upon conclusion of the Roswell Park Lecture entitled "Indications for Thyroid Surgery with Present-Day Knowledge of Antithyroid Drugs and Radioactive Iodine." Congratulations, Dr. Collier!

* * *

R. H. Springer, M.D., Centreville, recently addressed the Women's Clubs and the Lions Club of Centreville on the subject "Plans for Federalized Medicine."

The American Academy of Allergy offers a postgraduate course in allergy sponsored by the Faculty of Medicine of McGill University, Montreal, Canada, to be held in the amphitheatre of the Montreal Neurological Institute, June 14-16. For program and full information, write Bram Rose, M.D., Royal Victoria Hospital, Montreal.

* * *

The Industrial Congress of Physical Medicine, under the presidency of Lord Horder, will hold its annual Congress in London, July 14-19, 1952. For program and full details, write the Secretary at 45 Lincoln's Infields, London, W.C.2, England.

* * *

The American College of Chest Physicians will hold its 17th Annual Meeting at the Ambassador Hotel, Atlantic City, N. J., June 7-10. For program, write either Regent Wm. A. Hudson, M.D., 1553 Woodward Avenue, Detroit, or Governor Willard B. Howes, M.D., 1800 Tuxedo Avenue, Detroit.

* * *

The University of Michigan recently received \$7,000 from the Damon Runyon Cancer Fund for research, through the Fraternal Order of Eagles.

* * *

The American Academy of General Practice registered 4,222 at its San Francisco, 1951 Assembly, including 1,936 doctors of medicine and 628 residents and interns.

* * *

Leon DeVel, M.D., Grand Rapids, Medical Co-ordinator of the MSMS Rheumatic Fever Control Program, has been elected a member of the American Council on Rheumatic Fever of the American Heart Association.

Congratulations, Doctor DeVel!

* * *

In memoriam of Burt Russell Shurley, M.D., of Detroit, was published in the *Transactions American Academy of Ophthalmology and Otolaryngology*, January-February, 1951.

* * *

Russell F. Staudacher, for the past two years Associate Public Relations Counsel of the Michigan State Medical Society, recently announced his decision to join the staff of the American Medical Association as of May 1, 1951.

Mr. Staudacher has accepted an appointment with the Council On Medical Service headed by Mr. Thos. A. Hendricks and will become a staff associate.

Prior to his association with MSMS, Mr. Staudacher was active in public relations for several organizations. From 1947 to 1949, he was connected with Frank Block and Associates of St. Louis, Missouri, Public Relations Counselors, where he worked on the account of the Midwestern Manufacturers of Paperboard.

Air Corps public relations occupied his attention from 1942 to 1946 when he entered the Reserve Corps as a Major. He was a member of the Air Corps unit which made history with its air drop of the atomic bomb over Bikini in 1945 and before this served three years in the European Theater.

Mr. and Mrs. Staudacher (the latter having been a secretary of L. Fernald Foster, M.D., in his Bay City office) and their family will move to Chicago in June.

* * *

At the New Orleans Graduate Medical Assembly of March 5-8, 1951, the following Michigan Doctors of Medicine were registered: Drs. Frank M. Burroughs, Grandville; Jerome W. Conn, Ann Arbor; Fred P. Currier, Grand Rapids; James N. Dewane, Menominee; Isadore H. Gutow, Flint; J. J. Gutow, Flint; W. H. Kern, Garden City; H. D. McEachran, Iron Mountain; Robert J. Meade, Lansing; Paul E. Medema, Muskegon; George Moriarty, Detroit; Allan R. Peterson, Daggett; H. Marvin Pollard, Ann Arbor; William G. Winter, Holland; George H. Wynn, Adrian.

STANDARDS OF JMSMS ADVERTISERS

The advertising pages carry important messages from reliable, ethical, firms and are equally as significant to the reader as are the text pages. They furnish him with sources of information for reviewing products and services. By these means, he can learn of the changing variety of medical products suited to his specific need in his daily practice and for personal use. It is second nature for him to read his journal's advertising pages.

Furthermore, the doctor of medicine is aware of the standards required for acceptance of advertising in his journal; he co-operates by purchasing, or prescribing, featured products. The advertising standards are similar to those adopted for publications of the AMA.

The J. F. Hartz Company was host to the medical profession Friday evening, March 16, 1951, on the occasion of the formal opening of its new headquarters building at 780 W. Eight Mile Road, Ferndale, Michigan. The opening of the new Hartz laboratories and administration building was attended by hundreds of physicians. The entire Hartz staff, including laboratory technicians, was on hand to fully man and operate all equipment so

May, 1951



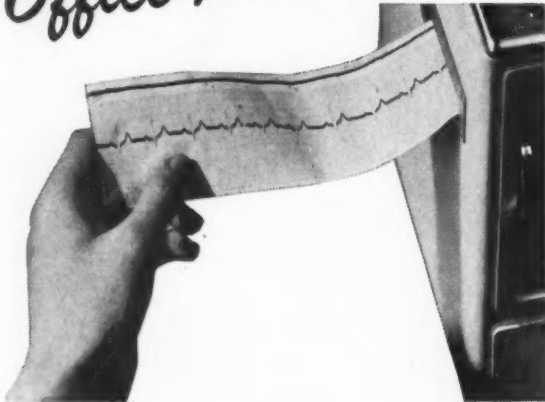
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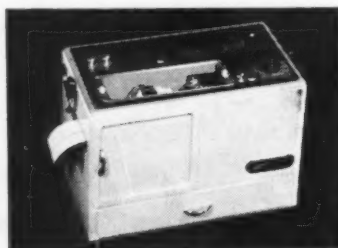
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M.D.

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NOTE: Use this certification only when forwarding copies. Otherwise leave it blank. Read carefully paragraph 8 of your agreement.

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Michigan Authors

P. C. Martineau, M.D., of Detroit, published an article, "Hamartomatous, Cholangiohepatoma," in *The Journal of the American Medical Association*, March 17, 1951.

Isadore Lampe, M.D., of Ann Arbor, published an article, "Malignant Neoplasms of the Tongue, Tonsil, and Hypopharynx: Evaluation of Radiation Therapy," in the *Transactions American Academy of Ophthalmology and Otolaryngology*, January-February, 1951.

J. A. Olson, M.D.; E. H. Steffensen, M.D.; R. W. Smith, M.D.; R. R. Margulis, M.D., and E. L. Whitney, M.D., of Detroit, published an article, "Use of Adrenocorticotrophic Hormone and Cortisone in Ocular Disease," in the *AMA Archives of Ophthalmology*, March, 1951.

E. H. Steffensen, M.D.; A. J. Wishbow, M.D.; F. O. Nagle, M.D.; R. W. Smith, M.D., and E. L. Whitney, M.D., of Detroit, published an article, "Topical Cortisone in the Treatment of Anderer Segment Eye Disease," in the *American Journal of Ophthalmology*, April, 1951.

William S. McNary, Executive Director, Michigan Hospital Service, Detroit, published an article, "Hospitals Must Make the Decision," in the *Hospitals Journal*, April, 1951.

Leo H. Bartemeier, M.D., Detroit, is the author of an

original article "The Attitude of the Physician" which appeared in *JAMA* of April 14, 1951.

Warren R. Mullen, Ann Arbor, President of the Student American Medical Association, is the author of an article entitled "The Student American Medical Association" which appears in *JAMA* of April 14, 1951.

Meyer O. Cantor, M.D., Charles S. Kennedy, M.D. and Roland P. Reynolds, M.D., Detroit, are the authors of an original article entitled "Gelfoam and Thrombin in Treatment of Massive Gastroduodenal Hemorrhage" which appeared in the December 1950 issue of *The American Journal of Surgery*.

* * *

Printer's Ink, a national magazine on advertising, says that under Government administration, the cost of National Service Life Insurance is more costly than the premium income. The magazine points out that it would be cheaper for the Government to pay out \$10,000 in cash to the family of each dead serviceman without the formality of keeping in operation the costly setup by which veterans' policies are handled. The premium income doesn't even begin to pay the cost of administration, much less the actual death claims. And yet, some people think the Government should run more things.

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**BON SECOURS HOSPITAL
Annual Clinic Day Program
Tuesday, June 5, 1951**

Morning Session—10:00 A.M.
Moderator—E. G. ALDRICH, M.D.

Multiple Polyposis of Colon and Rectum..... J. F. WENZEL, M.D.
Hiatus Hernia in Adults, Clinical Aspects..... L. E. HEAVNER, M.D.
Prolapse of the Gastric Mucosa..... R. J. REICHLING, M.D.
Adrenal Insufficiency..... N. W. DIEBEL, M.D.
Moderator—G. B. OHMART, M.D.
Sympathectomy in Arteriosclerotic Peripheral
Vascular Disease..... D. N. SWEENEY, M.D.
Cervicobrachialgia G. R. GRANGER, M.D.
The Anal Gland..... R. M. BURKE, M.D.
Treatment of Cerebral Angiospasm..... R. L. FISHER, M.D.
Early Ambulation..... E. J. TAMBLYN, M.D.

Luncheon—12:15 P.M.

Courtesy of—Sisters of Bon Secours Hospital

Evening Session

Moderator—L. E. HEAVNER, M.D.

Intussusception E. F. LANG, M.D.
Brief Summary of the Clinical
Physiology of Potassium..... H. STALKER, M.D.
Congenital Polycystic Disease of the Kidney
Report of Cases with Lantern Slides..... I. G. DOWNER, M.D.
Ventricular Tachycardia..... H. A. KLEIN, M.D.
Diverticula of Stomach and Duodenum..... H. M. FULLER, M.D.
The Surgical Treatment of Deafness..... J. E. COYLE, M.D.
Use of Blood, Plasma, and Blood Derivatives..... J. A. KASPER, M.D.
Male Infertility..... W. R. FLORA, M.D.

Luncheon—10:00 P.M.

Courtesy of—Medical Staff of Bon Secours Hospital

**THE SEVENTH ST. CLAIR COUNTY
CLINIC DAY**

Sponsored by the St. Clair County Medical Society
Tuesday, June 5, 1951

Morning Session—10:00 A.M.

Functional Uterine Bleeding
R. B. Greenblatt, M.D., Professor of Endocrinology
Medical College, University of Georgia
Diagnosis and Treatment of Testicular Defects
Warren Nelson, M.D., Professor of Anatomy
University of Iowa
Steroid Hormones in the Treatment of Various Types
of Malignancies
Edward Henderson, M.D., Medical Director
Schering Corporation, Bloomfield, N. J.

Luncheon—1:30 P.M.

Afternoon Session—2:30 P.M.

Physiology and Pathology of the Adrenal Cortex
Warren Nelson, M.D.
Cortisone and Insulin in the Treatment of Rheumatoid
Arthritis
Edward Henderson, M.D.
ACTH—Indication and Limitations
Robert Greenblatt, M.D.

Cocktail Hour—5:00 P.M.

Dinner—7:00 P.M.

Evening Session—8:00 P.M.

Quiz Program
Robert Greenblatt, M.D., Moderator
Edward Henderson, M.D.
Warren Nelson, M.D.

What Can Be Done For The Alcoholic?

Assuming that alcoholism is a disease and not a voluntary state, a great deal can be done for this type of patient.

The Keeley Institute, specializing exclusively in the care of the alcoholic for over half a century, has developed a smooth rehabilitation program to guide the patient back to a normal regimen of living.

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Nauseants, reactors and aversion methods are *not* employed—consequently the patient's confidence is quickly obtained and maintained.

Special emphasis is placed on the nutrition phase of treatment—an excellent cuisine is supplemented by vitamins, lipotropic factors and other dietary elements as indicated.

Careful evaluation of the patient's psychosomatic background is made by the attending staff of physicians, and group re-education supplemented by individual consultation helps restore a normal mental attitude.

Upon completion of the course, lasting about 4 weeks, the patient is referred back to his physician to whom a full progress report is given.

Both male and female patients are accepted.

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Arizona	608	\$50
Arkansas	1,225	\$20
California	10,634	\$40
Colorado	1,712	\$50
Delaware	315	\$25
Dist. of Columbia	1,736	\$40
Florida	2,038	\$40
Georgia	2,257	\$15
Idaho	404	\$30
Illinois	9,810	\$20
Indiana	3,700	\$35
Iowa	2,516	\$50
Kentucky	1,970	\$15
Louisiana	1,907	\$25
Maine	763	\$35
Massachusetts	6,500	\$35
Michigan	5,147	\$45
Minnesota	3,400	\$30
Mississippi	1,100	\$15
Missouri	3,600	\$15
Montana	443	\$50
Nevada	141	\$75
Nebraska	1,200	\$30
New Hampshire	640	\$40
New Jersey	5,295	\$25
New Mexico	386	\$30
New York	22,975	\$20
North Carolina	2,500	\$40
North Dakota	381	\$50
Ohio	7,600	\$15

Assess- ments

Oklahoma	1,489	\$42	.....
Pennsylvania	10,985	\$23	.....
Rhode Island	800	\$40	.....
South Carolina	1,178	\$20	.....
South Dakota	434	\$50	.....
Tennessee	2,158	\$25	.....
Texas	6,167	\$35	.....
Utah	635	\$25	.....
Virginia	2,233	\$25	.....
Vermont	370	\$35	.....
Washington	2,200	\$35	.....
West Virginia	1,452	\$15	\$10
Wisconsin	2,800	\$50	.....
Wyoming	196	\$25	.....

* * *

Ralph J. Campbell, a British doctor, "who escaped Utopia" to practice in San Francisco, has this to say in *The Insurance Field Magazine*:

"The hospitals are overloaded and the general practitioners are overloaded. I am going to quote you a figure which I am quite positive none of you will believe, but I am equally positive in telling you that it is a fact. The hospital that served the district where I was practicing had a waiting period for elective gynecological procedures of no less than three years. Now, they are not important conditions unless you happen to have one. If you are the person that is waiting for the 'gyn' procedure, it is desperately important for you, and yet the waiting period for those procedures was three years."

Ah, good old socialized medicine



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Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting June 4, July 9, August 6.
Surgical Anatomy and Clinical Surgery, two weeks, starting May 14, June 18, July 23.
Surgery of Colon and Rectum, one week, starting June 4, September 17.
Esophageal Surgery, one week, starting June 4.
Thoracic Surgery, one week, starting June 11.
Gallbladder Surgery, ten hours, starting June 18.
Breast and Thyroid Surgery, one week, starting June 25.
Fractures and Traumatic Surgery, two weeks, starting June 18.
- GYNECOLOGY**—Intensive Course, two weeks, starting June 18, September 24.
Vaginal Approach to Pelvic Surgery, one week, starting June 11, September 17.
- OBSTETRICS**—Intensive Course, two weeks, starting June 4, September 10.
- MEDICINE**—Intensive General Course, two weeks, starting October 1.
Gastroenterology, two weeks, starting October 15.
Gastroscopy, two weeks, starting July 16.
Electrocardiography and Heart Disease, two weeks, starting July 16.
Liver and Biliary Diseases, one week, starting June 4.
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One Year Full Time Clinical Course starting July 2.

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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

"YOUR PROSTATE GLAND." Letters from a Surgeon to His Father. By Reed M. Nesbit, M.D., Professor of Surgery, University of Michigan Medical School, Chief, Section on Urology, University Hospital, Ann Arbor, Michigan. Illustrations by Janet McLaughlin. Springfield, Illinois: Charles C Thomas, 1950. Price \$2.00.

Reed Nesbit, of Ann Arbor, has written a great book. He wanted to impart needful information to his father, and wrote a series of letters, telling for the benefit of a layman, the story of the prostate gland, its characteristics, foibles and what to do about it. During the course of these letters, Mr. Nesbit had prostate surgery, but the letters continued. Fortunately, the letters have been published and are available for any person, especially the aged one, to read and benefit. About one person in three, over sixty-five, has enlarged prostate, and about half of these give difficulties of urination, many needing surgical relief. There is a discussion of the four types of operations done. The section on cancer is a very understanding explanation of what cancer is. Dr. Nesbit tells of the ease of diagnosis of prostatic hypertrophy by rectal examination, and says when a cancer is found by examination of a patient who seeks examination it is mostly too late. He mentions that women have been taught to have their breasts examined routinely and any lump investigated. He advocates that men over sixty-five have the same kind of rectal examination, when early cancers can be found and properly eliminated. Autopsies show that one man in five who dies at over sixty-five has cancer of the prostate. Routine examinations will find these and offer prolonged and happier lives.

SEXUAL FEAR. By Edwin W. Hirsch, B.S., M.D., Attending Urologist, Englewood Hospital, Chicago, Ill.; former Associate in Urology, College of Medicine, University of Illinois; Member A.M.A., American Urological Society. Garden City, N. Y.: Garden City Publishing Co., Inc., 1950. Price \$3.00.

The first half of the book "Sexual Fear" is devoted to a recapitulation of the sexual practices of the ancients. The author apparently is attempting to give a background for fear on a sexual basis but only succeeds in rehashing oft-repeated fables and history. The author believes modern sexual fear dates from the French invasion of Italy under Charles VIII. He then discusses subjective and objective findings in the individual, attributing these symptoms to fear; fear founded on ignorance, Misconception and improper evaluation of published material relating to sex education is deplored. The treatment of sexual fear is a part of psychomatic medicine, time-consuming and exhausting, and must be preceded by a complete understanding of the patient's problem.

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*DIVELEY, REX L., "Foot Imbalance," J.A.M.A. 1510 et seq. (Nov. 17) 1934.

PROGRESS IN GYNECOLOGY. Volume II. Edited by Joe V. Meigs, M.D., Clinical Professor of Gynecology, Harvard Medical School; Chief of Staff of the Vincent Memorial Hospital, the Gynecological Service of the Massachusetts General Hospital; Surgeon, Pondville Hospital; Gynecologist, Palmer Memorial Hospital and Somers H. Sturgis, M.D., Clinical Associate in Gynecology, Harvard Medical School, Assistant Surgeon, Massachusetts General Hospital, Boston, Massachusetts. New York: Grune & Stratton, 1950. Price \$9.50.

This new and larger edition of Progress in Gynecology offers the reader the most recent scientific advances in this field, and airs controversial ideas in the treatment of most gynecological and some obstetrical disorders, as the opinions of 78 physicians and surgeons are recorded in 70 concise chapters. In addition to the contributions of American authors, there are chapters by outstanding men from Denmark, England, France and Sweden. Chapters carried over from Volume I have been rewritten.

Diagnostic methods, cytological studies and the general physiology of the female reproductive system are presented nicely and the functional disorders are outlined in very readable form. The interrelationship of endocrine glands is adequately handled in less than 100 pages stressing only the salient points.

Considerable space is given to studies of sterility and reproduction, artificial insemination, et cetera. Infections and benign growths are treated very briefly, but considerable space (180 pages) is devoted to malignant growths, with emphasis on radiation treatment and technique. There is a fine section on operative technique with excellent descriptive plates and photographs of the various steps of major gynecological procedures.

The section on preoperative and postoperative care stresses the prevention and treatment of complications of surgery in the light of recent research on these topics. A final chapter presents a most practical chart to use as a guide to the selection of commercial preparations of endocrine products used in gynecology. Each chapter is followed by a bibliography which permits the reader to augment his knowledge of any topic he finds of unusual interest.

S.B.W.

THE RHESUS DANGER. Its Medical, Moral, and Legal Aspects. By R. N. C. McCurdy, M.B., Ch.B., D.P.H. Pp. 138. London: William Heineman, Medical Books, Ltd., 1950. Price, 5 shillings.

This small, paper-bound volume gives a very excellent philosophical discussion not only of the Rh factor and the Treatment of Erythroblastosis but extends into other problem, such as, the adoption of children, contraception; sterilization, artificial insemination; divorce, and abortion. This material is presented in a refreshing manner, although the title is somewhat misleading for the actual amount of space devoted to the Rh factor and its associated problems is very small. It is recommended particularly because of the unbiased vein in which it deals with the controversial aspects of the subjects previously mentioned. It is written for both the physician and the layman.

A.A.H.

DIABETES GUIDE BOOK for the Physician. New York: American Diabetes Association, 1950.

This small book was prepared by the Committee on Education of the American Diabetes Association. It has a stiff paper cover, pocket size and contains in an orderly fashion the necessary dietic principles by which one may treat sufferers of diabetes. Food values, diabetic implications and values, with substitutes, and prepared diets of various caloric totals. We would say almost indispensable for a ready reference, which the doctor may give to his patient.

FUNCTIONAL ANATOMY OF THE LIMBS AND BACK—A Text for Students of Physical Therapy and Others Interested in the Locomotor Apparatus. By W. Henry Hollinshead, A.B., M.S., Ph.D., Head of the Section on Anatomy, Mayo Clinic, Rochester; Professor of Anatomy, Mayo Foundation, University of Minnesota. 341 pages with 122 figures. Philadelphia: W. B. Saunders Co., 1951. Price \$6.00.

This text is written for the student, particularly the non-medical student, but it has value to all who are interested in Physical Medicine. General information is

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covered in the early chapters that acquaints the reader with morphology and physiology which is important for his understanding of the anatomy and muscle function that follows.

The book is well illustrated with readily understandable drawings. These are particularly well done in the illustrations referring to muscle action.

For the medical student and graduate the book will be a source of ready reference and short review of functional anatomy and as such serves a useful purpose.

P.C.K.

THE PROSTATE GLAND. By Herbert R. Kenyon, M.D., Associate Clinical Professor, Department of Urology, New York University, Bellevue Medical Center. New York: Random House, 1951. Price \$2.95.

In this book, "The Prostate Gland" written for the laity, the author presents a comprehensive treatise which is enlightening without being alarming. Such a book, written in non-technical language, enables the individual to understand the disabilities due to the prostate to which all adult males may fall heir. The author first discusses the anatomy and physiology of the gland and includes the all-important functional disorders in relation to sexual activity and reproduction. True pathology includes infections and obstructions as well as the relationship of systemic diseases. In discussing treatment, a realistic yet optimistic attitude is followed and all types of surgery are fully discussed. Carcinoma is dis-

cussed as a problem, and while no punches are pulled as to the gravity of the condition, the advances in therapy and research in conjunction with therapy give the readers hope for comfort and even cure.

YOU AND YOUR HEART. A Clinic for Layman on the Heart and Circulation. By H. M. Marvin, M.D. New York: Random House, 1950. Price \$3.00.

"You and Your Heart" gives an exceptionally clear and understandable explanation of the normally functioning heart and circulatory system. It also offers a detailed explanation of the pathology of the heart and circulatory system. This information is presented in such a way that the average individual can understand it. The references to treatment, covering diet, exercise, nerve factors and medication, are presented so as to help the patient understand what the doctor is trying to accomplish. There is no question that the better the heart patient understands the nature of his ailment, the better attention he will give to his doctor's advice. I have submitted this book to a number of patients and feel it has been a definite help to us both.

M.J.C.

PROGRESS VOLUME to accompany Hyman's Integrated Practice of Medicine. An appraisal of latest developments in therapeutics prepared by Harold Thomas Hyman, M.D., to accompany his 4-volume Integrated Practice of Medicine. Contains cross reference to the original 4 volumes and an index system



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THE DOCTOR'S LIBRARY

to all 5 volumes. 734 pages. Philadelphia and London: W. B. Saunders Company, 1950. Price \$10.00.

The Progress Volume—a supplement to an integrated practice of medicine, has been thoroughly reviewed. The entire series has been a most valuable contribution to the science of medicine. The four previous volumes cover the entire field and the availability of the information needed in diagnosis and differential diagnosis is outstanding. The Progress Volume now offers the same ready suggestions on therapy. The advances in therapeutics are coming so fast that it is difficult for the physician to acquire detailed information from the journals in a concise form. In the Progress Volume all the latest information is presented so that it can be used as a guide in the application of any of the late therapeutic agents. This book is a valuable addition to the doctor's library.

M.J.C.

CANCER AS I SEE IT. By Henry W. Abelman, M.D., New York: Philosophical Library, 1951. Price \$2.75.

Dr. Abelman stresses the diagnosis of cancer early, and says that is where the control of the disease must start. He believes in the generic name cancer, and deplores the many names and classes of the disease which are recognized, and by their very number befog the issue. If a disease is malignant it is cancer in his book. He believes in the infectious nature of the disease, mentioned virus, parasites. His book is challenging, and well worth reading.

CONGENITAL PARALYSIS OF THE INFERIOR OBLIQUE

(Continued from Page 509)

as evidenced by failure of elevation of the eye to the horizontal plane, with the eye in full adduction.

2. Little if any secondary contracture of the direct antagonist (superior oblique).

3. As the eye is abducted, the limit of elevation will follow a straight line from the inner canthus to normal limits of elevations in the mid-line.

4. The affected eye in the temporal field will show a near normal muscle balance.

5. There is usually a widening of the palpebral fissure on adduction.

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